SEXUALLY TRANSMITTED DISEASE CONTROL GUIDELINES

Manitoba
Health

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INTRODUCTION

Syphilis and gonorrhea have been major public health concerns on this continent for many years and STD control programs have traditionally been directed primarily at these two infections. However, there is an ever-growing number of more recently recognized sexually transmissible diseases which cause considerable morbidity and mortality and which therefore have a significant public health impact.

"V.D. Program Guide" (J.N.R. Scatliff, 1977) was the first provincial publication to provide direction on control programs for STD. These present revised guidelines have been made necessary both because of new knowledge about and patterns of "traditional" STD, and the current "epidemic" of newer STD.

Optimal control strategies must be implemented for each specific disease and continuous efforts need to be made to evaluate and, if necessary, revise our control measures.

M.V. Fast, M.D.
Director, Communicable Disease Control

P. Matusko, R.N.
Program Co-ordinator, CDC/STD Control

E. Sherman, R.N.
Nursing Specialist, CDC/STD Control

L. Heise, R.N.
Public Health Nurse, CDC/STD Control

PREFACE

"Sexually Transmitted Disease Control Guidelines" is intended for all health workers who are involved in or will become involved in the control of sexually transmitted diseases (STD). It contains information about the epidemiology and management of sexually transmitted diseases which are prevalent in Manitoba and also includes STD control policies of Manitoba Health.

These guidelines are not intended to be used as a "rule book". Individual patients may present with unique problems and because of geographic locale, some regions may require altered approaches to disease control.

It is assumed that the persons using these guidelines will have some basic information about sexually transmitted diseases and this information is not repeated here. Neither have we provided detailed information on sexually transmitted diseases which are an isolated exception in Manitoba.

TABLE OF CONTENTS

Introduction	1
Preface	2
Sexually Transmitted Disease Control Program	5
Reporting of Sexually Transmitted Diseases	9
Guidelines for Interviewing	11
Guidelines for Contact Tracing	15
Education	17
Drugs for treatment of Sexually Transmitted Diseases	19
General Diagnostic Methods	21
Syphilis	25
Gonorrhea	35
Genital Chlamydia	43
Children with Sexually Transmitted Diseases	47
Human Immunodeficiency Virus infections and Acquired Immunodeficiency Syndrome	49
Chancroid	55
Other Sexually Transmissible Diseases	57
Appendix	
A: Regulation P210/R2 - Division II	83
B: Notification Card	85
C: Darkfield examination for syphilis	87
D: Laboratory diagnosis of gonorrhea	89
E: Laboratory diagnosis of chlamydia	93
F: Management of acute reactions to penicillin or other drugs — anaphylaxis protocol	95
Bibliography	97
Glossary	98

SEXUALLY TRANSMITTED DISEASE CONTROL PROGRAM

PROGRAM GOAL

A reduction in the incidence of sexually transmitted diseases and their complications in Manitoba.

PROGRAM MANDATE

Regulation P210/R2, Division II of the Public Health Act (Appendix A) provides the legal basis for the prevention and control of sexually transmitted diseases in Manitoba.

OVERALL OBJECTIVE

To achieve this goal it is necessary to have a single co-ordinated province-wide program dedicated to the optimal management of sexually transmitted diseases (STD).

All participants — clinicians dealing with STD, regional Manitoba Health staff, staff of the City of Winnipeg Health Department and staff in the Manitoba Health STD control section — must communicate effectively and all must have input into program planning and program evaluation activities.

GENERAL FUNCTION OF STD CONTROL SECTION

The Manitoba Public Health Act and its regulations require that the province maintain an effective program of STD control. The STD control section has the responsibility of ensuring the maintenance of this program.

The STD control section is a part of the Communicable Disease Control Directorate. The program responsibility line is through the Director of Communicable Disease Control to the Assistant Deputy Minister of Health.

The STD control section is responsible for:

1. Surveillance of disease trends.
2. Co-ordinating program planning.
3. Developing program priorities.
4. Monitoring, evaluating and revising existing programs.
5. Providing regions with standards and guidelines to assist them in program implementation.
6. Education at a provincial level.

In co-ordinating these functions, the opinions of the service sections and other appropriate professional groups are actively solicited.

SPECIFIC RESPONSIBILITIES OF STD CONTROL SECTION

The STD control section recognizes the role of the Manitoba Health regions and the City of Winnipeg Health Department in the management of STD. The STD control section:

1. Co-ordinates the STD control program.
2. Drafts recommendations for policy decisions and responds to inquiries from the Minister, Deputy Minister and Assistant Deputy Minister.
3. Participates in intra-and inter-departmental planning.
4. Maintains a current and functional master registry of cases of STD and their contacts. This provides the statistical base for the epidemiological surveillance of disease trends for program planning, monitoring, evaluation and

the development of recommendations for the revision of programs. The registry also expedites the exchange of information on cases and contacts. Accumulated data is provided to the Manitoba Health Regions and the City of Winnipeg Health Department in the form of regular reports or in response to requests.

5. Provides consultation services through specialized staff to physicians, regional staff and to staff of the City Health Department.
6. Ensures that objectives of the program are accurately reflected in the budget process after joint discussions between region and section.
7. Reviews and amends current STD reporting mechanisms.
8. Maintains communication with the STD control programs in other provinces and with the federal government.
9. Liaises with interested professional groups and institutions and actively involves the Cadham Provincial Laboratory (CPL) and other laboratories in the STD control program.
10. Initiates, participates in and utilizes studies and research to improve the STD control program in Manitoba.
11. Maintains a provincial supply of drugs recommended for the treatment of notifiable STD and distributes them to the regions at their request according to current policy.

EDUCATIONAL ACTIVITIES OF STD CONTROL SECTION

1. Assists professional organizations, universities and schools of nursing to initiate and maintain their own continuing education programs in STD.
2. Promotes the goal and overall objective of the STD control program with physicians through their professional association and in conjunction with the regional Medical Officer of Health (MOH) informs them of disease management recommendations.
3. Provides education for departmental and non-departmental professional personnel involved in the delivery of the STD control program.
4. Initiates, develops and carries out province-wide mass media campaigns directed to the general public in order to create a more positive attitude toward the prevention and management of STD.
5. Acts as a consultant to the Department of Education in the development of the Manitoba School Health Curriculum as it relates to the prevention and management of STD.
6. Ensures that visual aids and publications available through the Manitoba Health and Health Resource Centre, contain appropriate, current and factual information regarding the prevention, treatment, and management of STD.
7. Provides consultation to Directorates, other government departments and appropriate external agencies regarding risks, prevention, and management of STD.

GENERAL FUNCTIONS OF MANITOBA HEALTH REGIONS AND CITY OF WINNIPEG HEALTH DEPARTMENT IN THE STD CONTROL PROGRAM

It is the responsibility of the Manitoba Health regions and the City of Winnipeg Health Department to plan, implement, evaluate and manage the STD control services for their area in accordance with the provincial standards and guidelines.

SPECIFIC RESPONSIBILITIES OF MANITOBA HEALTH REGIONS AND CITY OF WINNIPEG HEALTH DEPARTMENT IN THE STD CONTROL PROGRAM

1. Deliver an effective STD control service in their area within the standards and guidelines established for the program.
2. Collaborate in program planning and implement new programs and initiatives as required in the standards and guidelines.
3. Target resources to high-risk groups and implement strategies in response to emergent STD problems, and in rural areas ensure adequate local access to health care resources.
4. Participate in the maintenance of an effective master registry.
5. Consult with regional hospitals and clinics to initiate and facilitate the organization of effective regional case and contact management systems.
6. Provide statistical data and maintain effective communications and reporting systems as required or requested by the STD control section.
7. Encourage the use of program protocols in the screening, diagnosis and management of cases and contacts.
8. Establish and maintain effective working relationships with physicians and other health care professionals involved in the STD control program.
9. Ensure that contacts of cases of notifiable STD receive appropriate management.
10. Distribute recommended drugs for the treatment of notifiable STD as requested by physicians in rural areas.
11. May participate in research projects.

EDUCATIONAL ACTIVITIES OF MANITOBA HEALTH REGIONS AND CITY OF WINNIPEG HEALTH DEPARTMENT

1. Inform, teach and counsel individuals, families and community groups on the risks, prevention, and management of STD.
2. Identify ongoing staff development needs of regional personnel and other health care providers involved in the delivery of the STD control program and develop plans to meet these needs.

REPORTING OF SEXUALLY TRANSMITTED DISEASE

A primary objective of the STD control program is the identification of those members of the community who have a sexually transmitted disease or may be incubating it.

Concerted efforts need to be made to elicit the names of all those contacts at risk. It is imperative to locate contacts who may be infected as soon as possible if these diseases are to be controlled.

Notification:

The prime purpose of the notification system is to allow for the interruption of the process of disease spread through epidemiological measures. Persons responsible for diagnosis and treatment should initiate communication with those responsible for control programs. Failure to notify Manitoba Health of infections may result in unnecessary illness in others. To be effective, notification should be made within the first 48 hours after a diagnosis has been made.

Notification Card (NH1) — (see Appendix B)

The most important element of notification is communication of information — from clinician to the Health Department and vise-versa. The notification card is the usual format through which diagnosticians report. Physicians may complete the card themselves, or provide the necessary information to the regional Medical Officer of Health (MOH) or to the STD Control Section at 945-6791 on laboratory-confirmed cases.

ACTIVITY	RESPONSIBILITY
Diagnosis and Treatment of STD in case	— **clinician**
↓	
Notification (via card or other means) to (i) regional MOH or (ii) STD Control Section	— **clinician**
↓	
Interview of case to include identification of contacts. It often follows notification but notification is not a prerequisite to initiating	— **clinician or public health nurse**
↓	
Tracing of contacts so they can be investigated and epi-treated. Contact information should be completed on each contact and a copy forwarded to the STD Control Section. If the contact cannot be traced, it is still necessary to complete the card with any information that is available.	— **public health nurse**

- If a contact of chlamydia or gonorrhea has not been located within 30 days after tracing is instituted, the tracing efforts should be abandoned. If a contact of syphilis has not been located by 60 days, further search is not likely to be helpful.

- Although physicians may choose to interview cases which they have diagnosed, and trace contacts of these cases, these are both very time-consuming processes. For this reason, it is generally preferable to have the PHN, specially trained in these techniques, carry out these tasks for urgent cases or if the physician prefers to request their assistance.

Remember

1. Time element is critical.

2. These are not diseases of two people alone.

GUIDELINES FOR INTERVIEWING

OBJECTIVES: (1) To educate the case about the infection.
(2) To obtain information about contacts so that they can be located and managed appropriately.

- The earlier a case is interviewed, the greater the likelihood of obtaining data useful for disease control. Therefore it is extremely important to conduct this interview without delay and certainly within the first 24 hours of notification if possible.
- All sexual activity during the critical period of infectivity should be discussed with the case. The time period for which the case is interviewed is determined by the stage of the infection or duration of disease and must always include the time from the day of treatment up to the time the interview is conducted.
- Under no circumstances should the interviewing process itself be hurried. It is essential to proper communication that the interviewer follow the prearranged protocol, allowing the interviewee time to develop a frame of mind which will encourage him/her to provide the information necessary for disease control.
- The content and order of the interview should follow the outline as provided on page 12. It has been designed to develop a sense of trust in the patient. The interviewer should demonstrate a personality that relaxes people and gains their confidence. The interviewer must be confident and forceful with a genuine belief in the program. The interviewer must be in control of the interview at all times. Loss of control may be regarded by the case as a sign of incompetence. Control is not flaunted but is demonstrated by the interviewer's tone of voice, attitudes, and behavior. The whole success of this interview will depend largely upon the disposition and personality of that interviewer.
- The interviewer must not assume that a person's sexual activity is confined to the opposite sex. It must be assumed that each individual may partake in homosexual as well as heterosexual relationships. Interviewers must discuss with each case various modes of transmission and sexual preferences without apology. In a like manner, sexual activity must not be assumed to be confined to one occasion, nor to one individual. An exhaustive inquiry should be made into these areas if that information is not already volunteered.
- The possible infection of wives, husbands and common-law partners must always be assumed on the basis of cohabitation. Possible infection of children might have to be considered in some cases.
- All interviewing should (particularly in emergent cases) be carried out face-to-face in a location where conversation cannot be overhead. It is important that the case is assured of complete privacy and confidentiality.
- The case should be assured that his/her name will not be revealed as the source of the information provided.
- Investigation in the field should begin as soon as possible after the interview. If subsequent follow-up in the field fails to produce at least one infectious partner, then the patient may need to be reinterviewed. A reinterview may also become necessary to obtain more information on partners already named.

INTERVIEW OUTLINE

I. General Section

A. Goals
1. Relax the patient
2. Establish an early analysis of the patient
3. Project an image of interviewer competence and understanding
4. Gather fundamental information for epidemiologic analysis

B. Method — modified direct approach to data gathering
1. Establish locating information
2. Assess "living with" situation
3. Determine length of residence in the city/town
4. Determine length of residence at given address
5. Discuss patient's occupation
6. Obtain name of referring source
7. Determine amount of education

II. Medical Section

A. Goals
1. Obtain a history of previous sexually transmitted diseases
2. Provide the patient with a basic knowledge of the disease
3. Establish the foundations for motivations
4. Analyze the patient's medical status

B. Method — educational discussion of patient's disease
1. Establish a history of STD tests
2. Establish a history of past STD
3. Obtain a detailed history of current or recent symptoms
4. Outline modes of transmission
5. Introduce the concept of the incubation period
6. Introduce the concept of asymptomatic disease
7. Demonstrate the signs of early disease
8. Analyze the patient's sexual patterns

III. Transition

A. Goals
1. Provide an understandable critical period
2. Set the stage for positive response to the request for contacts

B. Method
1. Utilize positively phrased statements
2. Avoid apologetic wording or voice inflection
3. Maintain a high degree of expectancy
4. Provide for a smooth cross-over into contact elicitation

IV. Contact and Location Information Section

A. Goals
   1. Elicit names of all critical period contacts
   2. Elicit names of all pertinent suspects
   3. Elicit complete locating information for all persons named

B. Method — positive motivational and problem solving approach toward:
   1. Elicitation of contacts' names
   2. Elicitation of accurate exposure dates
   3. Elicitation of exposure frequencies
   4. Elicitation of locating information
   5. Elicitation of suspects' names
   6. Elicitation of suspect locating information
   7. Determined persistence in pursuit of goals

V. Interview Conclusion

A. Goals
   1. Arrange for a reinterview if necessary
   2. Arrange for treatment follow-up if indicated

B. Method
   1. Set date, time, and place of reinterview
   2. Encourage appointment for follow-up examination

GUIDELINES FOR CONTACT TRACING

OBJECTIVES OF CONTACT TRACING

(1) To inform contacts of their risk.
(2) To educate contacts about disease transmission and symptomatology.
(3) To ensure that contacts are appropriately managed.

Contact tracing should be initiated as soon as possible after the interview of a diagnosed case has been conducted. Contacts should be informed of their risk during a **face-to-face meeting**. This is critical because:

- it is imperative to correctly identify the contact as the person being sought.
- teaching and learning is most successful in a face-to-face situation.
- this method stresses the seriousness and importance of the situation.
- it enables the contact to appreciate the public health nurse's efforts to maintain confidentiality.

The telephone will often be utilized to set up face-to-face meetings and in some situations may be the only means of informing contacts of risk.

INFORMING THE CONTACT:

- Identify the contact as the person you are looking for.
- Ensure privacy for your conversation.
- Inform the contact of risk in a positive manner.
- Respond to questions in an honest manner, always maintaining absolute confidentiality regarding the source of the information.
- Obtain history of any symptoms.
- Provide teaching in relation to the infection that the contact has been exposed to:
  (a) causative agent
  (b) manner of transmission
  (c) sites of exposure
  (d) asymptomatic versus symptomatic disease
- Explain expectations and rationale, e.g. "It is important that you see your doctor within two days so that appropriate tests can be done and treatment given."
- Where necessary, assist with the making of an appointment for a medical assessment. Ideally, this assessment should be carried out within two days of the interview.
- Leave a phone number for contact to call if the contact wishes to do so.

Having visited with the contact, the public health nurse should then notify the appropriate physician prior to the contact's appointment time. The public health nurse should inform the physician of the following:

- reason for contact's proposed visit.
- history obtained re: symptoms, lack of symptoms, sites to be tested
- recommended treatment.

This allows the physician to prepare for the contact's visit, ensure that the appropriate tests are done and that the proper epidemiologic treatment is given.

The public health nurse should then check with the physician's office to verify that the contact kept the appointment. This communication with the physician's office should be done within 24 hours of the contact's appointment time. If the contact has defaulted on the appointment, efforts should be made to locate the

contact and determine why the appointment was not kept. A new appointment should be made. If the contact has kept the appointment, the public health nurse should then check with the physician's office in one week to determine test results. If the contact presents clinical symptoms, it may be advisable to interview for sex partners at that time and to retain this information until the results of laboratory investigations are available. If the test results are negative, the interview data must be discarded.

The information regarding the contact investigation should be reported to STD Control on an appropriate form. Any additional information i.e. date of birth, next of kin, place of employment, aliases etc., should also be added to the contact information prior to its return.

EDUCATION

Specialist staff from the STD Control Section are available to the regions to provide educational sessions. The regions are encouraged to utilize the expertise of the STD staff so that the regions can provide case and contact management as outlined in the program guidelines. It is important that all those involved in STD diagnosis, treatment and follow-up have the opportunity to attend lectures, seminars and workshops which are planned and delivered jointly by the region and the STD Control Section.

NURSING EDUCATION

A course designed for STD Control termed "Epidemiology I" is available to all nurses and physicians working in the regions. The course is of three days duration and is designed to assist nurses to work comfortably and effectively with STD patients. The content includes:

1. A review of the disease process of the major sexually transmitted diseases.
2. Total case management.
3. Interviewing techniques.
4. Contact tracing.
5. STD in children.
6. STD and the law.
7. Completing forms for STD Control in Manitoba.

Lectures and seminars will be provided for nurses working in such areas as institutions, doctor's clinics, hospitals, etc. These sessions will be jointly planned and, where possible, delivered by regional and STD Control Section staff. Lectures on the management of sexually transmitted diseases are provided to all schools of nursing as part of their curriculum on communicable diseases.

8. Orientation of new staff to the STD program is available to all regions. This orientation is strongly recommended.

Please direct all requests and inquiries re nursing education to the Program Co-ordinator at the STD Control Section 945-6791.

PHYSICIAN EDUCATION

Most physician education is on a consulting basis with the infectious disease consultant to the STD Control Section, the Director of the STD Control Section and a nursing specialist. Other avenues of education are available through:

(a) seminars
(b) conferences
(c) lectures
(d) regional meetings
(e) newsletters

Please direct all requests for physician education to the Director of the STD Control Section or the Program Co-ordinator 945-6791.

PUBLIC EDUCATION

The STD Control Section recognizes the need to inform the public of the potential risk and complications of STD.

This is done by:

(1) planning and delivering provincial public awareness campaigns.
(2) providing consultation to regions interested in planning a regional campaign.
(3) preparing public health nurses, health educators etc. to inform the public through interest groups, classes etc.
(4) preparing pamphlets, posters and other informational material on STD for distribution to the public.

DRUGS FOR TREATMENT OF SEXUALLY TRANSMITTED DISEASES

Drugs for the curative treatment of notifiable sexually transmitted diseases (STD) are available **free of charge** from the STD Control Section, to all physicians in private practice, health centres and clinics in Manitoba. These drugs are stored and distributed by the Misericordia General Hospital Pharmacy. Federal Medical Services provide drugs to all nursing stations and hospitals supply their own drugs for the treatment of STD.

Only those drugs included in the Recommended Treatment Schedule are available.

An initial supply can be sent to individual physicians or clinics and replacement stock will be sent upon request.

These drugs are also available at regional health units throughout the province of Manitoba.

DRUGS AVAILABLE

- — Ampicillin
- — Aqueous Procaine Penicillin G (APPG, Wycillin)
- — Benzathine Penicillin (Bicillin)
- — Erythromycin
- * — Spectinomycin (Trobicin)
- * — Trimethoprim/Sulfamethoxazole (TMP/SMX)
- — Tetracycline
- — Probenecid

* Available when penicillinase-producing *Neisseria gonorrhoeae* is suspected or confirmed.

For assistance with concerns in obtaining drugs or supplies — write to:

Gillian Armstrong
Attention: Pharmacy, Misericordia General Hospital
99 Cornish Avenue
Winnipeg, Manitoba
R3C 1A2

or call 788-8235 during working hours.
Calls regarding emergencies can be made after hours to 774-6959.

GENERAL DIAGNOSTIC METHODS

The basis of all STD control programs is prompt and accurate diagnosis of cases followed by appropriate therapy and investigation of contacts.

The classical components of diagnosis of disease are a history, a physical examination, and appropriate investigation. With STD, it is particularly important that information is collected in a manner that establishes rapport between the case and clinician, assures accurate definition of the problem(s), and leads to successful case management.

In many instances the clinician obtaining this information will be a physician. However, nurse clinicians also play an important role in diagnosis, especially in remote areas and in community clinics.

GUIDE TO DIAGNOSTIC APPROACH WHERE STD IS SUSPECTED

1. Basic medical history:
   (a) Reason(s) for attendance
   (b) Problem description:
      (1) Symptom(s): onset, character, periodicity, duration, and relationship to sexual intercourse and urination.
      (2) Similarity to previous problems.
      (3) Medical problems of sex partner(s).
   (c) Occurrence, dates and treatments for previous STD.
   (d) Review of recent sexual activity:
      (1) Time since last sexual exposure.
      (2) Specific exposure site(s).
      (3) Illness among recent partner(s).
   (e) Other relevant history:
      (1) Recent antibiotic use: type, purpose, duration.
      (2) Drug allergy: drug, type of reaction, date.
      (3) Women only: date of last menses, unusual aspects of last menses, birth control method (if none, evaluate desire for family planning).
2. Routine physical examination:
   (a) For women:
      (1) Inspection of skin of face, trunk, forearms, palms and soles.
      (2) Inspection of oral mucosa and pharynx.
      (3) Inspection of pubic hair for lice and nits.
      (4) Inspection of external genitalia, perineum, and anus.
      (5) Examination of vagina and cervix using speculum.
      (6) Bimanual pelvic examination.
      (7) Examination for relevant lymphadenopathy.
   (b) For men:
      (1) Inspection of skin of face, trunk, forearms, palms and soles.
      (2) Inspection of oral mucosa and pharynx.
      (3) Inspection of pubic hair for lice and nits.
      (4) Inspection of penis including meatus, retraction of foreskin, and expression of any discharge from urethra.
      (5) Palpation of scrotal contents.

(6) Inspection of anus.
(7) Examination for relevant lymphadenopathy.

(c) For children:
(1) General physical examination.
(2) Inspection of the external genitalia and anus.
(3) Speculum examination is not routinely indicated in prepubertal girls.

3. Routine laboratory tests include:

(a) For women:
(1) Serologic test for syphilis (STS) at every visit. This may not be necessary if there is documentation of a negative test within the previous 90 days.
(2) Endocervical specimen for gonorrhea detection.
(a) culture on selective medium, or
(b) antigen detection, e.g. gonozyme
(3) Oropharyngeal and/or rectal culture for gonorrhea on selective medium when history indicates exposure or symptoms.
(4) Endocervical specimen for chlamydia by antigen detection, e.g. chlamydiazme.
(5) Cervical cytologic examination (pap smear) for those who have not had one in the past 12 months. (There is an association between some STDs and carcinoma of the cervix.)

(b) For men:
(1) STS at every visit. This may not be necessary if there is documentation of a negative test within the previous 90 days.
(2) Urethral gram stain is taken when patients give a history of recent discharge or if discharge is present on physical examination.
(3) Urethral specimen for gonorrhea:
(a) culture on selective medium, or
(b) antigen detection, e.g. gonozyme
(4) Oropharyngeal and/or rectal culture for gonorrhea on selective medium if history indicates exposure or symptoms.
(5) Urethral specimen for chlamydia by antigen detection, e.g. chlamydiazme.

(c) For children:
(1) Serologic test for syphilis.
(2) Specimen (vaginal for prepubertal girls, urethral for boys) for gonorrhea detection
(a) culture, or
(b) antigen detection, e.g. gonozyme.
(3) Specimen (vaginal for prepubertal girls, urethral for boys) for chlamydia detection. See laboratory methods.
(4) Rectal and pharyngeal cultures on selective medium for gonorrhea should be performed prior to treatment if vaginal or urethral discharge is present.

NOTIFIABLE SEXUALLY TRANSMITTED DISEASES

The following sections contain specific information regarding diagnosis, treatment and follow-up of the five sexually transmitted diseases which are reportable in Manitoba: syphilis, gonorrhea, chlamydia, chancroid and Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infections. Some of the information in this section is deliberately repeated in other sections since different sections of these guidelines are intended to be, to some extent, independent.

SYPHILIS

ETIOLOGY: Syphilis is caused by a spirochete *Treponema pallidum*.

CLINICAL: The natural course of syphilis is arbitrarily divided into the following stages:

i) an incubation period of about three weeks (10-100 days).

ii) a primary stage characterized by a non-painful chancre marking the point of entry of *T. pallidum* and regional lymphadenopathy.

iii) a secondary bacteremic stage associated with generalized mucocutaneous lesions and lymphadenopathy which occurs 4-6 weeks after the chancre and may persist for 12 months.

iv) a period of subclinical infection (latent syphilis) detected only by serologic testing.

v) a late or tertiary stage characterized by progressive disease involving principally the ascending aorta and/or central nervous system.

Primary, secondary and early latent syphilis are considered to be infectious.

INCUBATION PERIOD: Ten to 100 days, usually three weeks.

COMMUNICABILITY:

Variable. Syphilis is infectious during primary and secondary stages and also in mucocutaneous recurrences. Congenital transmission is most probable during primary and secondary maternal syphilis but can occur in the latent period. Adequate penicillin treatment usually ends infectivity within 24-48 hours.

SEROLOGIC TESTS FOR SYPHILIS

Serologic tests for syphilis are indispensable for diagnosis of individual patients, for following the effect of therapy and for screening purposes. They detect antibodies formed during the course of syphilitic infection and are of two basic types:

1. Reagin or Non-treponemal tests

Reaginic antibodies are immunoglobulins directed against a lipoidal antigen that results from the interaction of host tissues with *T. pallidum* and/or from *T. pallidum* itself.

The standard reagin test is the Venereal Disease Research Laboratory (VDRL) slide test in which heated serum is tested for its ability to floculate a suspension of cardiolipin-lecithin antigen. The rapid plasma-reagin card test (RPR) or the automated reagin test (ART) based on the same general principles, are more sensitive than the VDRL.

Reports from the Cadham Provincial Laboratory (CPL) refer to the VDRL as the screening test. (However, quantitation of antibodies is measured by RPR.)

Serial reagin tests are useful to determine the stage of the disease; a four fold rise in titre may indicate:

— a recent infection,
— re-infection in an adequately treated patient,
— relapse in an inadequately treated person, or
— rarely, an acute false positive reaction.

Adequate treatment of infectious syphilis is indicated by a four-fold or greater decline in titre within one year.

Titres should generally become non-reactive or weakly reactive in 12 months following treatment of primary syphilis and in 24 months after treatment for secondary syphilis. Treatment of late latent or late syphilis usually has little or no effect on the titre and should not be used to gauge the adequacy of the treatment. Titres tend to become lower with time, but frequently remain reactive in low titre.

Prozonal Reaction.

A prozone reaction occurs in nontreponemal tests when an excess amount of anticardiolipin (reaginic) antibody interferes with the test result. Under these circumstances the laboratory may report the serum as weakly reactive, atypical or even non-reactive. The inhibitory effects of the excess antibody can be overcome by diluting the serum. This may occur in 1 to 2% of individuals with secondary syphilis and the occurrence of this phenomenon must be recognized. Indicating the clinical history on the requisition allows the laboratory to perform other tests e.g. confirmatory test.

2. Specific Treponemal tests

Confirmatory Test

T. pallidum hemagglutination assay (TPHA-TP), or microhemag-glutination assay for *T. pallidum* (MHA-TP) also measures specific treponemal antibody, is easier to perform than the FTA-abs, and is as specific as the FTA-abs, though slightly less sensitive during primary disease. Reports from CPL refer to this as the confirmatory test.

Reference Test

Fluorescent treponemal antibody-absorption (FTA-abs) test is an indirect immunofluorescent antibody test using *T. pallidum* from rabbit testis as the antigen. Its interpretation is subjective and requires great attention to detail. Its principal use is to verify the diagnosis of syphilis. It usually remains positive for life. Reports from CPL refer to this as the reference test.

The comparative reactivities of these tests are shown in Table I.

TABLE I
COMMONLY USED SEROLOGIC TESTS FOR SYPHILIS

TEST	SENSITIVITY*	
	Primary	**Secondary**
I. Non-treponemal (reaginic) tests		
1) VDRL	70%	99%
2) RPR	80%	99%
II. Specific treponemal tests		
1) FTA-abs	85%	100%
2) TPHA-TP	65%	100%

*Percentage of cases detected by the test.

DIAGNOSIS:

In establishing a diagnosis, it is essential that the stage of syphilis be accurately assessed and documented in order to ensure appropriate management of cases and contacts.

I. Primary Syphilis

1. Chancre **plus** demonstration of *T. pallidum* either by darkfield (DF) microscopy or by direct fluorescent antibody — *T. pallidum* (DFA-TP) techniques in material from a chancre or regional lymph node. (See Appendix C)

or

2. Chancre **plus** (a) positive reagin tests plus positive specific treponemal test and no previous history of syphilis.

or

(b) 4-fold rise in reagin test plus positive specific treponemal test in a previously treated case.

or

(c) history of exposure within 10-100 days to a partner with a confirmed diagnosis of infectious syphilis.

Note: The existence of a chancre is essential to the diagnosis and an intensive search should be made for it on the external genitalia, anal canal, vagina, cervix and oropharynx.

II. Secondary Syphilis

Clinical signs* plus positive reagin tests and positive specific treponemal tests. A positive DF or FA on an aspirate from skin lesions or lymph nodes confirms the diagnosis.

*Clinical signs include:

1. Skin rash: bilateral symmetrical macular, papular, follicular, papulosquamous, or pustular skin lesions.
2. Condylomata lata (syphilis warts)
3. Mucous patches
4. Generalized lymphadenopathy
5. Fever and malaise
6. Splenomegaly
7. Alopecia areata
8. Iritis.

Note: The diagnosis of secondary syphilis requires clinical evidence of disease.

III. Early Latent

Asymptomatic patient with reactive reagin tests and positive treponemal tests who is known to have had within the previous 12 months:

a) non-reactive serological tests.

or

b) symptoms highly suggestive of primary or secondary syphilis.

or

c) exposure to a sex partner with confirmed infectious syphilis.

IV. Late Latent

Asymptomatic patient with:

a) newly discovered reactive reagin tests and positive treponemal tests and who does not meet the other criteria for early latent syphilis.

and

b) central nervous system involvement ruled out by examination of cerebrospinal fluid (see neurosyphilis).

Note: In both early and late latent syphilis, no clinical signs of infection are present.

V. Late Syphilis

A broad range of signs and symptoms particularly involving the central nervous system (CNS) and/or cardiovascular system plus reactive reagin or treponemal tests.

NEUROSYPHILIS is a form of late syphilis, in which the following abnormalities are present in the cerebrospinal fluid (CSF):

a) positive reagin test in CSF

and/or

b) elevated cells and/or elevated protein in CSF.

CNS symptoms may or may not be present.

VI. Congenital Syphilis

Syphilitic infection of the fetus depends both upon duration of infection in the mother (the longer the duration of an untreated infection, the less likely that the fetus will be infected) and the stage of pregnancy at which maternal infection is acquired (fetal infection is less common during the first trimester of pregnancy).

Infection of the fetus may result in:

(1) Intrauterine death and stillbirth.
(2) A liveborn infant with active (secondary) lesions.
(3) A liveborn infant who develops secondary lesions during infancy.
(4) A liveborn child who develops late manifestations particularly around puberty.

Signs of congenital syphilis:

- interstitial keratitis
- nerve deafness
- developmental anomalies of teeth and skull
- periosteal involvement of tibial bones
- nasal discharge
- skin lesions

Criteria for early congenital syphilis:

1. Early congenital syphilis is diagnosed definitively when *T. pallidum* is demonstrated by darkfield (or FA) examination of material from nasal discharges or skin lesions of a neonate.

2. A presumptive diagnosis applies to any infant in whom a ≥ four-fold increase in titer over the infant's previous titer is demonstrated. A presumptive diagnosis is made in symptomatic neonates with reactive reagin tests if their mothers were not treated adequately for syphilis.
   NOTE: If the neonate is asymptomatic, has a positive serology, and the mother was not treated adequately for her infection with penicillin, the baby should be treated without awaiting criteria for a presumptive diagnosis.
   NOTE: A peripheral blood sample from the baby and not cord blood, should be sent for testing along with a sample of the mother's blood. An FTA-ABS for the detection of specific IgM antibodies will be performed on the baby's blood.

MANAGEMENT OF SYPHILIS CASES:

1. Immediate antimicrobial therapy for all cases of infectious syphilis.
2. Interview within one working day whenever possible.
3. Evaluation one week after onset of therapy to document clinical response.
4. Repeat reagin tests:
   (a) infectious syphilis and congenital syphilis at 3, 6 and 12 months after treatment.
   (b) syphilis of more than one years duration at 3, 6, 12 and 24 months after treatment.
   (c) neurosyphilis should be managed in consultation with an infectious disease specialist.
5. Retreatment should be considered when:
   (a) clinical signs or symptoms of syphilis persist or recur.
   (b) there is a 4-fold increase in titre with a reagin test.
   (c) a reagin test showing a high titre initially fails to show a 4-fold decrease within a year.

Patients who require retreatment should be retreated according to the schedules recommended for syphilis of more than 1 year's duration. In general, a patient should be re-treated only once since patients may maintain stable, low titres when nontreponemal tests are used or may have irreversible anatomical damage.
All cases of infectious syphilis should abstain from sexual activity until they and their sex partners are appropriately treated and clinical signs are no longer present.

EVALUATION OF SEX CONTACTS:

It is extremely important that **all** relevant sex contacts of cases of infectious syphilis be identified and evaluated promptly.

Patient's Stage	Examine All Sex Contacts Exposed:
PRIMARY SYPHILIS	— during the 3 months prior to onset of chancre. and Up to and including the interview date, e.g. chancre was first noted on June 3, the patient was treated on June 15 and interviewed on June 16; the interview period is March 3 up to and including June 16.
SECONDARY SYPHILIS	— during the 6 months prior to onset of clinical symptoms. and Up to and including the interview date, e.g. palmar rash was noted on August 6, the patient was diagnosed, interviewed and treated on August 9; the interview period is from February 6 up to and including August 9.
EARLY LATENT	— during the 12 months prior to making the diagnosis, e.g. the patient is diagnosed on May 3 and interviewed on May 4; the interview period is May 4 of the preceding year to May 4 of the present year.

If, however, the interviewer can elicit the following history, the interview period can be established more accurately.

(a) If the patient has had a negative VDRL in the last year, he is interviewed back 3 months from the date of the negative VDRL.

(b) If the patient gives a **reliable** description of a primary chancre, he can be interviewed 3 months back from the first day of the appearance of the chancre.

(c) If the patient gives a reliable description of secondary symptoms he can be interviewed 6 months back from the first day of the appearance of the secondary symptoms.

NON-INFECTIOUS SYPHILIS:	— syphilis of over 1 year's duration, includes the stages of late latent and late syphilis including neurosyphilis and cardiovascular syphilis) — Only those contacts who have been regular long term sex partners need to be investigated.

CHILDREN OF PATIENTS WITH NON-INFECTIOUS SYPHILIS

It is suggested that children of these patients be determined to be of good health and free of the sequelae of congenital syphilis. If any child shows evidence of congenital syphilis, serologic tests for syphilis (both reaginic and specific treponemal tests) should be done on all children of the family. If the results are positive, further investigation is indicated. (See Congenital Syphilis)

MANAGEMENT OF CONTACTS:

All sex partners should be clinically evaluated (see General Diagnostic Methods) and have a screening (reagin) test for syphilis.

Persons who have been exposed to infectious syphilis within the preceding 3 months should be epidemiologically treated as for early syphilis.

TREATMENT:

Recommended Treatment Regimens

I. Infectious Syphilis

Infectious syphilis (primary, secondary, early latent syphilis) should be treated with:

Benzathine penicillin G: 2.4 million units total, IM, in divided doses, at a single session

PENICILLIN-ALLERGIC PATIENTS

Patients who are allergic to penicillin should be treated with:

Tetracycline HCL: 500 mg, by mouth, 4 times a day for 15 days

Tetracycline appears to be effective, but has been evaluated less extensively than penicillin. Patient compliance with this regimen may be difficult, so care should be taken to encourage optimal compliance.

Penicillin-allergic patients who cannot tolerate tetracycline should have their allergies confirmed. For these patients there are 2 options:

1. If compliance and serologic follow-up can be assured, administer *erythromycin* 500 mg, by mouth, 4 times a day for 15 days.
2. If compliance and serologic follow-up cannot be assured, the patient should be managed in consultation with an expert.

II. Syphilis of More Than One Year's Duration

The optimal treatment schedules for syphilis of greater than 1 year's duration have been less well established than schedules for early syphilis. In general, syphilis of longer duration requires more prolonged therapy.

Examination of cerebrospinal fluid is recommended for patients with syphilis of greater than 1 year's duration to exclude neurosyphilis.

Therapy is recommended for established cardiovascular syphilis. However, antibiotics may not reverse the pathology associated with this disease.

Syphilis of more than 1 year's duration, (latent syphilis of indeterminate or more than 1 year's duration, cardiovascular, or late benign syphilis) **except** neurosyphilis should be treated with:

Benzathine penicillin G: 2.4 million units, IM, in divided doses, once a week for 3 successive weeks (7.2 million units total)

PENICILLIN-ALLERGIC PATIENTS

There are no published clinical data that adequately document the efficacy of drugs other than penicillin for syphilis of more than 1 year's duration. Cerebrospinal fluid examinations should be performed before initiating therapy with these regimens.

Patients who are allergic to penicillin should be treated with:

Tetracycline HCL: 500 mg, by mouth, 4 times a day for 30 days. Patient compliance with this regimen may be difficult, so care should be taken to encourage optimal compliance.

Penicillin-allergic patients who cannot tolerate tetracycline should have their allergies confirmed. For these patients there are 2 options:

1. If compliance and serologic follow-up can be assured, administer *erythromycin* 500 mg, by mouth, 4 times a day for 30 days.
2. If compliance and serologic follow-up cannot be assured, the patient should be hospitalized and managed in consultation with an expert.

CEREBROSPINAL FLUID EXAMINATION

Cerebrospinal fluid (CSF) examination should be done for patients with clinical symptoms or signs consistent with neurosyphilis. This examination is also recommended for other patients with syphilis of greater than 1 year's duration to exclude asymptomatic neurosyphilis.

Neurosyphilis

Potentially effective regimens, none of which have been adequately studied, include:

Aqueous crystalline penicillin G: 12-24 million units, IV, per day (2-4 million units every 4 hours) for 10 days, followed by *benzathine penicillin G*, 2.4 million units, IM, in divided doses, weekly for 3 doses.

OR

Aqueous procaine penicillin G: 2.4 million units, IM, daily plus *probenecid* 500 mg, by mouth, 4 times a day, both for 10 days, followed by *benzathine penicillin G*, 2.4 million units, IM, weekly for 3 doses.

PENICILLIN-ALLERGIC PATIENTS

Patients with histories of allergy to penicillin should have their allergy confirmed and be managed in consultation with an expert.

III. Syphilis in Pregnancy

Evaluation of Pregnant Women

All pregnant women should have a nontreponemal serologic test for syphilis, such as the VDRL or RPR test, at the time of the first prenatal visit. (The treponemal tests such as the FTA-ABS test should not be used for routine screening.) For women suspected of being at high-risk for syphilis, a second nontreponemal test should be done during the third trimester.

If the mother is known to have positive syphilis serology and is inadequately treated, the following should be obtained on the infant venous blood:

1. VDRL
2. MHA-TP
3. IGM-FTA (Abs)

The baby should be carefully examined for any signs of congenital syphilis.

Seroreactive patients should be expeditiously evaluated. This evaluation should include a history and physical examination, as well as a quantitative nontreponemal test and a confirmatory treponemal test.

If the FTA-Abs test is nonreactive and there is no clinical evidence of syphilis, treatment may be withheld. Both the quantitative nontreponemal test and the confirmatory test should be repeated within 4 weeks. If there is clinical or serologic evidence of syphilis or if the diagnosis of syphilis cannot be excluded with reasonable certainty, the patient should be treated as outlined below.

Patients for whom there is documentation of adequate treatment for syphilis in the past need not be treated again unless there is clinical or serologic evidence of reinfection such as darkfield-positive lesions or a four-fold rise in titre when a reagin test is used.

RECOMMENDED TREATMENT REGIMENS

Patients at all stages of pregnancy should be treated with penicillin used in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of nonpregnant patients.

PENICILLIN-ALLERGIC PATIENTS

For patients at all stages of pregnancy who have documented allergy to penicillin:

1. If compliance and serologic follow-up can be assured, administer erythromycin in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of non-pregnant patients. Infants born to mothers treated with erythromycin during pregnancy for infectious syphilis should be treated with penicillin.
2. If compliance and serologic follow-up cannot be assured, the patient should be hospitalized and managed in consultation with an expert.

Tetracycline is not recommended in pregnant women because of potential adverse effects on the fetus.

FOLLOW-UP

Women who have been treated for infectious syphilis during their pregnancy should have monthly quantitative nontreponemal serologic tests for the remainder of the current pregnancy. Women who show a four-fold rise in titre should be treated again. After delivery, follow-up is as outlined for nonpregnant patients.

IV. Congenital Syphilis

Congenital syphilis may occur if the mother has syphilis during pregnancy. If the mother has received adequate penicillin treatment during pregnancy, the risk to the infant is minimal. However, all infants should be examined carefully at birth and at frequent intervals thereafter until nontreponemal serologic tests are negative.

Infected infants are frequently asymptomatic at birth and may be seronegative if the maternal infection occurred late in gestation. Infants should be treated at birth if maternal treatment was inadequate, unknown, or with drugs other than penicillin, or if adequate follow-up of the infant cannot be ensured.

NOTE: Infants with congenital syphilis should have a CSF examination before treatment.

SYMPTOMATIC INFANTS OR ASYMPTOMATIC INFANTS WITH ABNORMAL CEREBROSPINAL FLUID

Aqueous crystalline penicillin G: 50,000 units/kg, IM or IV, daily in 2 divided doses for a minimum of 10 days

or

Aqueous procaine penicillin G: 50,000 units/kg, IM, daily for a minimum of 10 days.

ASYMPTOMATIC INFANTS WITH NORMAL CEREBROSPINAL FLUID

Benzathine penicillin G: 50,000 units/kg, IM, in a single dose.

Although benzathine penicillin has been previously recommended and widely used, published clinical data on its efficacy in congenital neurosyphilis are lacking. If neurosyphilis cannot be excluded, the aqueous crystalline or procaine penicillin regimen is recommended. Only penicillin regimens are recommended for neonatal congenital syphilis.

After the neonatal period, penicillin therapy for congenital syphilis should be with the same dosages used for neonatal congenital syphilis. For larger children the total dose of penicillin need not exceed the dosage used in adult syphilis of more than 1 years duration. After the neonatal period, the dosage of tetracycline for congenital syphilis in patients who are allergic to penicillin should be individualized but need not exceed dosages used in adult syphilis of more than one years duration. Tetracycline should not be given to children less than eight years of age.

SCREENING GUIDELINES FOR SYPHILIS

Recommended for:

1) The following high risk individuals should have screening tests every three months
   - persons with multiple sex partners
   - individuals with repeated STD
   - partners of the above
2) Persons presenting with any sexually transmitted disease
3) Prenatals
   - routinely in first trimester
   - high risk as outlined above

GONORRHEA

ETIOLOGY: *Neisseria gonorrhoeae*, a gram negative diplococcus.

CLINICAL PRESENTATION:

1. Genitourinary

MALE

- 20-40% asymptomatic
- purulent urethral discharge
- dysuria
- edema & erythema around the urinary meatus

Complications

- epididymitis

FEMALE

- up to 80% asymptomatic
- cervicitis or urethritis
- vaginal discharge scant to copious
- dysuria

Complications

- oophoritis
- endometritis
- salpingitis

} also referred to as pelvic inflammatory disease (PID)

- peritonitis
- ectopic pregnancy
- infertility

2. Pharyngeal — generally considered to be asymptomatic
   At risk are those persons who engage in oro-genital sexual activity
3. Rectal gonorrhea
   - often asymptomatic
   - mucoid discharge
   - tenesmus
   - blood streaked stool

   Routine culture taken from the rectum of females will increase the yield by 3-5%.
   Rectal infection in males is indicative of homosexual exposure.

INCUBATION PERIOD: Usually 2-7 days, sometimes longer.

COMMUNICABILITY: May extend for months if untreated especially in asymptomatic persons. Effective therapy usually ends communicability within hours.

DIAGNOSIS:

Male:

Any one of:

1. Intracellular gram-negative diplococci (GND) present on gram stain of urethral exudate

   or

2. *N. gonorrhoeae* isolated on culture of urethral exudate **or** any other site i.e. pharynx, rectum, or eye

   or

3. Positive antigen detection test on urethral exudate e.g. gonozyme

   or

4. Urethral discharge in a male with history of sexual contact with a laboratory-confirmed case in the preceding 2-7 days. Laboratory confirmation should always be sought in this situation.

Female:
Any one of:

1. *N. gonorrhoeae* isolated on culture from endocervical secretions or any other site i.e. pharynx, rectum, or eye

or

2. Positive gonococcal antigen detection test on urethral/cervix exudate e.g. gonozyme

or

3. Vaginal discharge in a female with history of sexual contact with a laboratory-confirmed case in the preceeding 2-7 days. Laboratory confirmation should always be sought in this situation.

Children (less than 12 years old):

1. *N. gonorrhoeae* isolated on culture from any site.

or

2. Gram-negative diplococci present on gram stain of urethral or vaginal exudate are technically diagnostic but should always be confirmed by culture.

Note: A child presenting with a vaginal, urethral or a rectal discharge (or with any suggestion of sexual abuse) requires cultures from these three sites as well as the pharynx before the treatment is initiated.

Newborn: *N. gonorrhoeae* isolated by culture from any site i.e. urethra, vagina, rectum, pharynx, eyes, umbilicus.

ANTIBIOTIC-RESISTANT N. GONORRHOEAE

Infections due to resistant organisms like penicillinase-producing *N. gonorrhoeae* (PPNG), tetracycline or spectinomycin-resistant *N. gonorrhoeae* are clinically indistinguishable from those due to susceptible strains and can only be diagnosed by culture technique. They constitute a public health emergency and must be **treated and investigated promptly when diagnosed**.

MANAGEMENT OF CASE

1. Serologic test for syphilis if not done within preceding 3 months.
2. Immediate antimicrobial therapy according to exposed sites.
3. Interview within five working days.
   Repeaters (persons with more than one documented episode of STD in the preceding 12 months) women with PID, individuals with PPNG and other high risk individuals should be interviewed within one working day.
4. Test of cure 3-5 days after completion of therapy for repeaters, women with PID, individuals with PPNG, other high risk individuals, and in children under 12.

Cases should abstain from sexual contact until they and their contacts have completed a course of therapy.

MANAGEMENT OF GONOCOCCAL INFECTIONS IN PREGNANCY, AT DELIVERY AND IN THE POST NATAL PERIOD

All high risk pregnant women should have endocervical tests for *Neisseria gonorrhoeae*.

If women are found to have gonorrhea during pregnancy or at the time of delivery, they should be treated with drug regimens of amoxicillin, ampicillin or aqueous procaine penicillin, each with probenecid as described elsewhere. Women who are allergic to penicillin or probenecid should be treated with *spectinomycin* 2.0 g IM. *Erythromycin* in the dosage recommended under chlamydial infection can be added to treat coexistent chlamydial infection. Tetracycline should not be used in pregnant women because of potential adverse effects for the fetus.

The most common form of gonococcal infection in infants who are born to mothers with **untreated** gonorrhea is conjunctival infection, but the mucous membranes of the vagina, urethra, pharynx or rectum may also be colonized and therefore all sites should be tested.

At birth these infants should be treated with a single injection of *aqueous crystalline penicillin* G 50,000 units IM or IV for full term infants or 20,000 units IM or IV for low birth weight infants. Topical prophylaxis for neonatal opthalmia is not adequate treatment for infections at other sites and clinical illness requires additional treatment.

Mothers who are found to have gonorrhea in the postnatal period should be investigated for possible co-existing sexually transmitted diseases i.e. *Chlamydia trachomatis*. The mother should be treated appropriately with a combined regimen of penicillin and tetracycline (erythromycin if breast feeding).

The baby should be examined carefully for ophthalmia neonatorium, vulvovaginitis, urethritis, pharyngitis or disseminated disease. If infection is suspected, the appropriate site(s) should be tested.

If six weeks or more have elapsed since birth and the infant has no clinical evidence of disease, it may not be necessary to perform tests.

EVALUATION OF SEX PARTNERS:

All sex contacts at risk (see below) should be examined, tested at all exposed orifices and should receive epidemiologic (prophylactic) treatment as outlined for cases. All should have a screening test for syphilis.

Case	Contacts
	Examine, test and provide epidemiologic treatment to all sex contacts exposed:
Male or Female with symptomatic uncomplicated gonorrhea	— 1 month prior to onset of symptoms in the case up to and including the interview date, e.g. case noted symptoms on June 1, was tested on June 4, diagnosed on June 6 and interviewed on June 10, the interview period is May 1 - June 10.
Male or Female with asymptomatic or complicated gonorrhea	— 3 months prior to case's diagnosis, e.g. case diagnosed on June 6 and interviewed on June 10; the interview period is March 6 - June 10.
Male or Female with repeated gonorrhea (i.e. ≥ 2 infections in the past 12 months)	— 3 months prior to diagnosis of the case, e.g. case diagnosed and treated for symptomatic gonorrhea on April 1 and again on June 6 and interviewed on June 10; the interview period is March 6 - June 10.

TREATMENT:

The following guidelines for the treatment of gonococcal infection take into account several observations:

- the increasing incidence of infections due to penicillinase-producing *N. gonorrhoeae* (PPNG); the emergence of tetracycline-resistant gonococci in several geographic areas,
- the high frequency of coexisting chlamydial and gonococcal infections, and
- the increased recognition of the serious complications of chlamydial and gonococcal infections. These guidelines do not attempt to be a comprehensive list of all possible treatment regimens. Rather, they seek to provide guidance for regimens that meet general criteria of efficacy, safety, ease of administration, and cost.

I. Uncomplicated Infection in Adults

An important concern in the treatment of gonorrhea is coexisting chlamydial infection and on theoretical grounds a combined regimen (outlined below) is very attractive. (It should be noted that its efficacy and side effects have not been evaluated.)

The combined regimen includes:

1. *Ampicillin:* 3.5 gm by mouth
   OR
   Aqueous Procaine Penicillin G: 4.8 million units IM
   (in divided doses)
   PLUS
2. *Probenecid:* 1.0 gm by mouth
   PLUS
3. *Tetracycline:* 500 mg by mouth, QID X 7 days

SPECIAL NOTE

Tetracycline or aqueous procaine penicillin G (APPG) is the preferred therapy for pharyngeal gonococcal infection. Pharyngeal infection is not effectively treated by either the amoxicillin or ampicillin regimens.

A homosexual man with uncomplicated gonococcal infection should be treated with *aqueous procaine penicillin* G 4.8 million units, plus 1.0 g of probenecid. If he is allergic to penicillin, use *spectinomycin* 2.0 g, IM, in one injection. Both of these regimens provide adequate treatment for urethral and anorectal gonococcal infection. However, spectinomycin is ineffective in the treatment of pharyngeal gonococcal infection.

OTHER CONSIDERATIONS

Patients other than homosexual men who are allergic to penicillins or probenecid should be treated with oral tetracycline. Penicillin-allergic patients who cannot tolerate tetracyclines may be treated with *spectinomycin*, 2.0 g, IM, in one injection.

Patients with incubating syphilis (seronegative without clinical signs of syphilis) are **likely** to be cured by all the above regimens except spectinomycin.

TREATMENT FAILURES

The patient in whom gonorrhea persists after treatment with one of the non-spectinomycin regimens above should be treated with 2.0 gm. of spectinomycin IM (See PENICILLINASE-PRODUCING NEISSERIA GONORRHOEAE). Recurrent gonococcal infections after treatment with the recommended schedules may be due to reinfection and indicate a need for improved contact tracing and patient education. Since PPNG infection is a cause of treatment failure, post-treatment isolates should be tested for penicillinase production.

DRUGS NOT RECOMMENDED

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in the treatment of syphilis, they have no place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

II. Penicillinase-Producing Neisseria gonorrhoeae (PPNG)

Patients with proven PPNG infection or who are likely to have acquired gonorrhea in areas of high PPNG prevalence and their sex partners should receive *spectinomycin* 2.0 g, IM, in a single injection. Tetracycline may be added to treat co-existent chlamydial infection. Patients with positive cultures after spectinomycin therapy should be treated with *cefoxitin* 2.0 g, IM, in a single injection plus *probenecid* 1.0 g, by mouth; OR *cefotaxime* 1.0 g, IM, in a single injection without probenecid. A daily single dose of nine tablets of *trimethoprim/sulfamethoxazole* (80 mg/400 mg) for five days should be used to treat pharyngeal gonococcal infection due to PPNG. Spectinomycin and cefoxitin are ineffective in pharyngeal infections.

III. Gonococcal Infections in Pregnancy

The following are recommended regimens for treatment of gonococcal infections during pregnancy:

1. *Amoxicillin:* 3.0 g by mouth
   or
   Ampicillin: 3.5 g by mouth
   or
   Aqueous Procaine Penicillin G: 4.8 m.u. IM
   (in divided doses).
   plus
2. *Probenecid:* 1.0 g by mouth
   plus
3. *Erythromycin base* 500 mg q.i.d. by mouth for 7 days

Pregnant women who are allergic to penicillin or probenecid should be treated with *spectinomycin* 2.0 g I.M. plus erythromycin as recommended above. Tetracycline should not be used in pregnant women because of potential adverse effects for the fetus.

IV. Infants Born to Mothers With Gonococcal Infections

The infant born to a mother with gonorrhea is at high risk of infection and requires treatment with a single injection of *aqueous crystalline penicillin G:* 50,000 units, IM or IV, for full-term infants or 20,000 units, IM or IV, for low-birth-weight infants. Topical prophylaxis for neonatal ophthalmia is not adequate treatment for infections at other sites. Clinical illness requires additional treatment.

V. Neonatal Gonococcal Infections

GONOCOCCAL OPHTHALMIA

Neonates with gonococcal ophthalmia should be hospitalized and isolated for 24 hours after initiation of treatment. Untreated gonococcal ophthalmia is highly contagious and may rapidly lead to blindness. *Aqueous crystalline penicillin G* 50,000 units/kg/day, IV, in two doses should be administered for seven days. Eyes should be irrigated immediately with saline or buffered ophthalmic solutions and then at least at hourly intervals as long as necessary to eliminate discharge. Topical antibiotic preparations alone are neither sufficient nor required when appropriate systemic antibiotic therapy is given. Both parents of a newborn with gonococcal ophthalmia must be tested and treated.

COMPLICATED INFECTION

Neonates with arthritis and septicemia should be hospitalized and treated with *aqueous crystalline penicillin G* 75,000 - 100,000 units/kg/day, IV, in 4 divided doses for at least seven days. Meningitis should be treated with *aqueous crystalline penicillin G* 100,000 units/kg/day, IV, divided into three or four doses and continued for at least ten days.

VI. Gonococcal Infections of Older Children (12 years)

(Please also see Management of Gonorrhea in Children)

Children who weigh 100 lbs. (45 kg) or more should receive adult regimens. Children who weigh less than 100 lbs. should be treated as follows:

UNCOMPLICATED DISEASE

Uncomplicated vulvovaginitis and urethritis can be treated at one visit with *amoxicillin* 50 mg/kg plus *probenecid* 25 mg/kg (maximum 1.0 g), both given by mouth OR with *aqueous procaine penicillin G* 100,000 units/kg, IM, plus *probenecid*, by mouth, 25 mg/kg (maximum 1.0 g). The latter regimen is recommended for proctitis and pharyngitis.

PENICILLINASE-PRODUCING NEISSERIA GONORRHOEAE

Children with infection due to PPNG should be treated with *spectinomycin* or *cefotaxime* in appropriate doses.

SPECIAL CONSIDERATIONS

Topical and/or systemic estrogen therapy are of no benefit in vulvovaginitis. Long-acting penicillins, such as benzathine penicillin G, are not effective. All children should have follow-up cultures, and the source of infection should be identified, examined, and treated.

ALLERGY TO PENICILLINS

Children who are allergic to penicillins should be treated with *spectinomycin* 40 mg/kg, IM. Children older than 8 years may be treated with *tetracycline* 40 mg/kg/day, by mouth, in 4 divided doses for 5 days. For treatment of complicated disease, the alternative regimens recommended for adults may be used in appropriate pediatric dosages.

VII. Gonococcal Ophthalmia in Adults

Adults with gonococcal ophthalmia should be hospitalized and treated with *aqueous crystalline penicillin G:* 10 million units, IV, daily for 5 days. For PPNG, use *cefoxitin* 1.0 g or *cefotaxime* 500 mg, IV, 4 times a day. Eyes should be irrigated immediately with saline or buffered ophthalmic solutions and then at least at hourly intervals as long as necessary to eliminate discharge. Cases must have careful ophthalmic follow-up to deal with ocular complications.

VIII. Disseminated Gonococcal Infection

Hospitalization is usually indicated, especially for those who cannot reliably comply with treatment, have uncertain diagnosis, or have purulent joint effusions or other complications.

There are several, acceptable treatment schedules for the gonococcal arthritis-dermatitis syndrome. These include the following:

Aqueous crystalline penicillin G: 10 million units, IV, per day until improvement occurs, followed by amoxicillin 500 mg or ampicillin 500 mg, by mouth, four times a day to complete at least seven days of antibiotic treatment.

or

Amoxicillin/ampicillin: amoxicillin 3.0 g or ampicillin 3.5 g, by mouth, each with probenecid 1.0 g, followed by amoxicillin 500 mg or ampicillin 500 mg, by mouth, four times a day for at least seven days.

or

Tetracycline HCL: 500 mg, by mouth, four times a day for at least seven days. Tetracycline HCL should not be used for complicated gonococcal infection in pregnant women.

or

Cefoxitin/cefotaxime: cefoxitin 1.0 g or cefotaxime 500 mg, either given four times a day IV for at least seven days (treatment of choice for disseminated infections caused by PPNG).

or

Erythromycin: 500 mg, by mouth, four times a day for at least seven days.

SPECIAL CONSIDERATIONS

Open drainage of joints other than the hip is not indicated. Intraarticular injection of antibiotics is unnecessary.

IX. Acute Pelvic Inflammatory Disease (PID)

(Endometritis, Salpingitis, Parametritis, and/or Peritonitis)

Acute pelvic inflammatory disease refers to the acute clinical syndrome attributed to the ascending spread of microorganisms, unrelated to pregnancy or surgery, from the vagina and endocervix to the endometrium, fallopian tubes, and/or contiguous structures.

Etiologic agents include *N. gonorrhoeae*, *C. trachomatis*, anaerobic bacteria and facultative gram-negative rods. In the individual patient it is often impossible to differentiate among these agents. Therefore, treatment regimens should be used that are active against the broadest range of these pathogens.

INPATIENT TREATMENT

- Regimen A:
  Doxycycline: 100 mg, IV, twice a day
  plus
  Cefoxitin: 2.0 g, IV, 4 times a day

Continue drugs IV for at least 4 days and at least 48 hours after patient improves. Continue *doxycycline* 100 mg, by mouth, twice a day after discharge from the hospital to complete 10-14 days of therapy.

Comment: This regimen provides optimal coverage for *N. gonorrhoeae*, including PPNG, and *C. trachomatis*. It may not provide optimal treatment for anaerobes.

- Regimen B:
  Clindamycin: 600 mg, IV, 4 times a day
  plus
  Gentamicin or *tobramycin:* 2.0 mg/kg, IV, followed by 1.5 mg/kg, IV, 3 times a day in patients with normal renal function.

Continue drugs IV for at least four days and at least 48 hours after the patient improves. Then continue clindamycin 450 mg by mouth 4 times daily to complete 10-14 days total therapy.

Comment: This regimen provides optimal activity against anaerobes and facultative gram-negative rods, but may not provide optimal activity against *C. trachomatis* and *N. gonorrhoeae*.

- Regimen C:
  Doxycycline: 100 mg, IV twice a day
  plus
  Metronirdazole 1.0 gm, IV twice a day

Continue drugs I.V. for at least 4 days and at least 48 hours after patient improves. Then continue both drugs at same dosage orally to complete 10-14 days of therapy.

AMBULATORY TREATMENT

Cefoxitin: 2.0 g, IM, or *amoxicillin:* 3.0 g, by mouth, or *ampicillin:* 3.5 g, by mouth, or *aqueous procaine penicillin G:* 4.8 million units, IM, at 2 sites; each along with *probenecid* 1.0 g, by mouth.
plus
Doxycycline: 100 mg, by mouth, twice a day for 10-14 days.
Tetracycline HCL 500 mg, by mouth, 4 times a day can also be used, but is less active against certain anaerobes.

Comment: Cefoxitin or an equivalently effective cephalosporin plus doxycycline (or tetracycline) provides activity against *N. gonorrhoea*, including PPNG, and *C. trachomatis*.

Note: The intrauterine device is a risk factor for the development of PID. Although the exact effect of removing an IUD on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis is unknown, removal of the IUD is recommended soon after antimicrobial therapy has been initiated. When an IUD is removed, contraceptive counseling is necessary.

SCREENING GUIDELINES FOR N. GONORRHOEA

1. High risk prenatals
2. Women who are having an intrauterine device inserted
3. Women attending for birth control counselling
4. Women having a therapeutic abortion
5. Women with more than one sex partner (at discretion of clinician)
6. Women whose partner is not monogamous (at discretion of clinician)

GENITAL CHLAMYDIA

ETIOLOGY: *Chlamydia trachomatis* — an obligate intracellular bacterium. At present this is the most common single cause of urethritis and cervicitis in North America.

CLINICAL:

Male
- 10-15% asymptomatic
- urethritis
- urethral discharge
- dysuria

Complications
- epididymitis

Female
- 15% asymptomatic
- cervicitis
- vaginal discharge
- dysuria

Complications
- salpingitis
- pelvic inflammatory disease (PID)
- ectopic pregnancy
- infertility

Persons with asymptomatic infection unknowingly act as a reservoir for *C. trachomatis* and may continually transmit the organism to unsuspecting partners.

INCUBATION PERIOD: Five to 14 days or longer.

COMMUNICABILITY: Unknown.

DIAGNOSIS:

Male:
Any one of:
1. Positive antigen detection (chlamydiazyme) test on urethral cells
   or
2. Urethral discharge in a male with history of sexual contact with a laboratory confirmed case in the preceding **five** to **fourteen** days.

Female:
Any one of:
1. Positive antigen detection test (chlamydiazyme) on cervical cells
   or
2. Cervical discharge in a female with history of sexual contact with a laboratory confirmed case in the preceding **five** to **fourteen** days.

Children: *C. trachomatis* identified by antigen detection, of urethral, vaginal or rectal specimen. (Only Microtrak recommended — see Laboratory Testing).

MANAGEMENT OF CASES:

1. Immediate antimicrobial therapy.
2. Screening test for syphilis to rule out concomitant infection.
3. Screening test for *N. gonorrhoeae* to rule out concomitant infection.
4. Interview within five working days if possible. Repeaters (persons who have had more than one episode of STD documented during the preceding 12 months) women with PID and other high risk individuals should be interviewed within one working day whenever possible.
5. Test of cure four weeks after completion of therapy for prenatals, repeaters, women with PID, and high risk individuals.

EVALUATION OF SEX PARTNERS:

Cases should be interviewed for all sex contacts for one month prior to the first appearance of symptoms or three months prior to the date of positive test results if asymptomatic and up to the date of interview.

MANAGEMENT OF CONTACTS:

All sex contacts should be evaluated (see General Diagnostic Methods), have appropriate sites tested for *C. trachomatis* and receive epidemiologic treatment after the appropriate tests are done. Treatment is as for cases.

All cases should refrain from sexual activity until they and their contacts have completed a course of therapy.

TREATMENT:

Infections caused by *C. trachomatis* are the most prevalent sexually transmitted diseases today. The importance of serious complications related to chlamydial infections has been established.

I. Uncomplicated Urethral, Endocervical or Rectal Infection in Adults

RECOMMENDED TREATMENT REGIMENS

Tetracycline hydrochloride (HCL): 500 mg, by mouth, four times a day for at least seven days

or

Doxycycline: 100 mg, by mouth, twice a day for at least seven days

ALTERNATIVE REGIMENS

(For patients in whom tetracyclines are contraindicated or not tolerated)

Erythromycin: 500 mg, by mouth, four times a day for at least seven days or erythromycin ethylsuccinate: 800 mg by mouth, four times a day for seven days.

Sulfonamides are also active against *C. trachomatis*, but have not been extensively studied.

II. Chlamydial Urogenital Infections During Pregnancy

Treatment should be given to pregnant women who have laboratory-proven *C. trachomatis* infections.

THE SUGGESTED TREATMENT IS:

Erythromycin 500 mg, by mouth, four times a day on an empty stomach for at least seven days.

For women who cannot tolerate this regimen, a decreased dose of 250 mg, by mouth, four times a day should be used for at least fourteen days.

Note: Lactating Women

The optimal dose and duration of antibiotic therapy for lactating women have not been established. There are currently no completely acceptable alternative regimens for women who are allergic to erythromycin or cannot tolerate erythromycin. In case of proven treatment failure, the women should be treated again with erythromycin in either of the dosage schedules outlined above.

Testing and treatment of the male partner(s) with tetracycline at the same time is an important part of the therapeutic regimen.

III. Children

Children who weigh 100 lbs (45 kg) or more should receive adult regimens. Children who weigh less than 100 lbs. should be treated as follows:

Erythromycin 50 mg/kg/day by mouth (not to exceed 2 g/day) given in four divided oral doses for fourteen days. If erythromycin cannot be tolerated: *Sulfisoxazole* 150 mg/kg/day given in 4 daily oral doses for 2-3 weeks (not to exceed 2 gm/day).

IV. Newborns

Infants born to mothers with chlamydial infection at time of delivery should have their eyes and nasopharnyx tested for chlamydia. Microtrak is required for the nasapharnygeal test. The newborn should be treated with oral *erythromycin* syrup 50 mg/kg/day in four divided doses for two weeks. Any infant that is test positive at time of delivery should be retested at four to six weeks post treatment.

V. Established Chlamydial Conjunctivitis of the Newborn

For all cases of ophthalmia neonatorum, appropriate tests should be done to rule out *Neisseria gonorrhoeae* as the cause.

The diagnosis of chlamydial conjunctivitis can be established by antigen detection test or Giemsa-stained conjunctival scrapings.

Treatment consists of oral *erythromycin* syrup 50 mg/kg/day in 4 divided doses for at least 2 weeks. There is no indication that topical therapy provides additional benefit. If inclusion conjunctivitis recurs after therapy, erythromycin treatment should be reinstituted for an additional 1-2 weeks.

VI. Treatment for Chlamydial Pneumonia of Infancy

For established cases of lower respiratory disease due to *Chlamydia trachomatis*, the recommended therapy is:

Oral *erythromycin* syrup 50 mg/kg/day in 4 divided doses for 14 days. The optimal duration for therapy has not been established.

Note: Chlamydial conjunctivitis of the newborn and chlamydial pneumonia in the infant is a marker for a genital chlamydial infection in the mother and the mother should be tested and treated.

SCREENING GUIDELINES

Screening is recommended for asymptomatic women at **high** risk for STD and for women prior to insertion of an intrauterine device. High risk patients include those with multiple sex partners, a recent history of or a contact with a sexually transmitted disease, or females presenting for therapeutic abortion. Antigen detection tests are **not** indicated for screening of low risk, asymptomatic women (e.g. as part of an annual examination or a prenatal examination).

CHILDREN WITH SEXUALLY TRANSMITTED DISEASES

SYPHILIS, GONORRHEA AND CHLAMYDIA

The approach to children under the age of 12 years with these STD is different than that for older adolescents and adults. It is recommended that all household contacts and any persons named by a parent (or guardian) or the child who had unsupervised access to the child for 30-100 days (depending on disease) prior to the diagnosis in the child, be tested. This includes all siblings who live in the home, the parents and the relatives who have been living or staying in the house. Also included may be babysitters or relatives or friends where the child may have been staying. It is recommended that these contacts have trisite testing (cervical/urethral, rectal and pharyngeal) and VDRLs done within 5 days. Epidemiologic treatment is only indicated for sex contacts named by the case.

These STD are rarely, if ever, transmitted by non-sexual contact, and since infection in children under 12 must be assumed to be the result of sexual abuse, child protection agencies are also involved in ensuring a safe environment for these children. It is important that the appropriate child protection agency (this varies from jurisdiction to jurisdiction) be notified of any case of gonorrhea, syphilis or chlamydia in a child.

From a communicable disease control point of view it is important to remember that contacts are traced so that they can be appropriately managed and the spread of infection interrupted. Identification of positive contacts can never be interpreted as identification of the perpetrator of the abuse. For this reason, information on contacts of children is treated with the same confidentiality as is information on contacts of adults. However, it should also be noted that a shared goal for both the health department and the child protection agencies is that the best interests of the child be served. To achieve this goal, continued co-operation of both agencies is essential.

HUMAN IMMUNODEFICIENCY VIRUS INFECTIONS AND ACQUIRED IMMUNODEFICIENCY SYNDROME

ETIOLOGY: Human Immunodeficiency Virus (HIV) a human retrovirus.

CLINICAL:

Infection with HIV can produce a very varied clinical picture, ranging from an acute seroconversion illness to AIDS many years later. Infection may be asymptomatic or symptomatic.

Acute infection following first exposure to the virus is usually asymptomatic and may occur up to about six weeks after the contact. When symptoms do occur they are often non-specific. A glandular fever-like illness has been described at the time of the acute seroconversion. The patient suffers from fever, malaise, lethargy, myalgia, arthralgia, lymphadenopathy, and sore throat. An acute reversible encephalopathy with disorientation, loss of memory and consciousness and personality change has also been described at seroconversion, as has acute meningitis, myelopathy, and neuropathy.

Probably not all of those who have seroconverted will progress to chronic infection. Those who do not probably go into a latent phase of infection. Nevertheless, it is prudent to assume that the individual is still infectious despite this latency. A positive antibody test to HIV indicates only that a person has been exposed to the virus and not that he or she has gained any natural immunity.

Chronic infection may also be asymptomatic. The clinical features described consist of cytopenias, minor opportunistic infections and skin conditions, lymphadenopathy, and the AIDS related complex (ARC). More recently, peripheral neuropathies, myelopathy, and encephalopathy have been seen in patients before they have developed AIDS.

Persistent Generalized Lymphadenopathy

The lymphadenopathy seen in chronic infection has been termed the persistent generalized lymphadenopathy syndrome (PGL). The definition of this syndrome is:

Enlarged nodes at least 1 cm in diameter in two or more (non-contiguous) extrainguinal sites that persist for at least three months in the absence of any current illness or medication known to cause enlarged nodes.

The nodes are symetrically affected, and those most often enlarged are in the posterior and anterior cervical chains and axillary and submandibular regions. Other less common sites are submeatal, postauricular, epitrochlear, and retroperitoneal. About a third of patients also have associated splenomegaly.

Several series of patients with persistent generalized lymphadenopathy have been studied prospectively for a number of years. The proportion with the syndrome who progress to AIDS varies from 10 to 30%, but the proportion increases the longer the patients are followed up.

AIDS RELATED COMPLEX

Patients who have some of the constitutional symptoms and signs of AIDS without the opportunistic infections or tumours found in the end stage disease are described as having the AIDS related complex (ARC). The term covers a wide range of disease. The concept is of less use now that an antibody test has been developed but can still be of use to the clinician in identifying particularly ill patients, some of whom will progress to AIDS.

The AIDS related complex is diagnosed in a person who presents with any two or more signs/symptoms which have been present for three months or longer and any two or more abnormal laboratory values:

Symptoms/signs:
Fever: ≥ 38° C intermittent/continuous
Weight loss: >10%
Lymph nodes: persistent generalized lymphadenopathy
Diarrhea: intermittent/continuous
Fatigue that reduces physical activity
Night sweats

Laboratory Abnormalities
Lymphopenia, leukopenia
Thrombocytopenia
Anaemia
Reduced ratio of T4:T8 (>2 SD)
Reduced T helper cells (>2 SD)
Reduced blastogenesis
Raised globulins
Cutaneous anergy

OPPORTUNISTIC INFECTIONS AND TUMORS (AIDS)

The two main clinical manifestations of AIDS are tumors and a series of opportunistic infections. Kaposi's sarcoma is the commonest original tumour described but non-Hodgkin's lymphoma (usually extranodal) and squamous carcinomas of the mouth and anorectum have also been described.

The many opportunistic infections associated with AIDS affect virtually any system of the body. *Pneumocystic carinii* pneumonia is the commonest opportunistic infection and presenting feature in patients with AIDS. Other organisms can also cause pneumonia in patients with AIDS: bacteria (*Haemophilus influenzae*, *Streptococcus pneumoniae*, *Branhamella catarrhalis*, group B streptococcus, and mycobacteria) viruses (cytomegalovirus and herpes simplex) and fungi (cryptococcus). Infections also occur affecting the central nervous system. The organisms are protozoal (toxoplasma), viral (cytomegalovirus and herpes simplex), bacterial (mycobacteria), and fungal (aspergillus, candida, cryptococcus). Finally, the gastrointestinal tract can be infected with protozoa (cryptosporidium, *Isospora belli*, and microsporidia), viruses (cytomegalovirus and herpes simplex), fungi (particularly candida), and bacteria (*Mycobacterium avium intracellulare*, *Mycobacterium tuberculosis*, and salmonella).

Progression

Not everyone infected with HIV develops AIDS. Cohort studies give some idea of the natural history. Different rates of progression might be accounted for by more virulent cofactors for progression in some of the groups and the fact that some of those studied had been infected for longer than the period studied. Nevertheless, there is no doubt that the longer the natural history is observed the greater the proportion who will progress from seroconversion to AIDS.

The clinical spectrum is enlarging all the time. The originally described manifestations of Kaposi's sarcoma and *Pneumocystis carinii* pneumonia may have represented the presentation of a short incubation illness, and possibly those who develop AIDS after a longer period may have different clinical presentations. This already seems to be occurring, with the appearance of new clinical phenomena such as other tumours and neurological disease. Other conditions increasingly recognized as part of end stage disease are lymphoid interstitial pneumonitis, granulomatous hepatitis, and an enteropathy.

The median survival of patients after diagnosis of AIDS varies with the presenting manifestation. In America survival is about nine months for patients with *Pneumocystis carinii* pneumonia and 31 months for those suffering from Kaposi's sarcoma.

Classification system for human immunodeficiency virus:

Because infection with AIDS can manifest itself in many ways, from asymptomatic infection to AIDS, the Centers for Disease Control have attempted to classify the range of HIV infection into four groups.

Group I	Acute infection
Group II	Asymptomatic infection
Group III	Persistent generalized lymphadenopathy
Group IV	Other diseases
Subgroup A	Constitutional disease
Subgroup B	Neurological disease
Subgroup C	Secondary infectious disease
Category C-1	Specified secondary infectious diseases listed in the CDC surveillance definition for AIDS
Category C-2	Other specified secondary infectious diseases
Subgroup D	Secondary cancers
Subgroup E	Other conditions

Incubation Period: — Unknown. Epidemiologic evidence suggests that duration from exposure to onset of symptoms has a minimum range from about 6 months to 5 years with a mean of 2 years in transfusion-associated cases.

Communicability — Unknown. Presumed to extend from asymptomatic period through appearance of opportunistic disease.

TRANSMISSION

How the Virus is Spread

- HIV has been shown to be spread from an infected person to an uninfected person by:
  - sexual contact (penis/vagina, penis/rectum, mouth/rectum, mouth/genital)
  - sharing needles or "works" used in injecting drugs,

- transfusion or injection of infectious blood or blood fractions.

It can also be spread from an infected woman to her fetus or newly born baby.

An individual can be infected without having symptoms of AIDS or appearing ill. Infected individuals without symptoms can transmit the infection to others. Once infected, a person is presumed infected for life, but actual symptoms may not develop for many years.

A single exposure to the virus may result in infection.

How the Virus is NOT Spread

- There is no evidence that the virus is spread through casual social contact (shaking hands, social kissing, coughing, sneezing, sharing swimming pools, bed linens, eating utensils, office equipment, being next to or served by an infected person). There is no reason to avoid an infected person in ordinary social contact.
- It is not spread by the process of giving blood; new transfusion equipment is used for each donor.
- It is not spread by sexual intercourse between individuals who have maintained a sexual relationship exclusively with each other assuming that they have not been infected through contaminated blood, blood factors, IV drug abuse, or a previous sexual partner.

Risk Groups

1. Homosexual/bisexual men.
2. Intravenous drug abusers.
3. Recipients of multiple blood or blood product transfusions prior to 1986.
4. Children born to mothers infected with HIV.
5. Persons with multiple sex partners.
6. Sex contacts of risk group members.

Risk Activities

1. Multiple sex partners, especially anonymous partners.
2. Anal intercourse.
3. Intravenous drug abuse.

DIAGNOSIS

At the present time, blood can routinely be tested only for antibodies which form in response to the virus. The blood test is available only at the request of a physician and should only be done after appropriate counselling has taken place.

Positive Antibody Test

If antibodies to HIV are found in the blood, it means the person has been infected with this virus at some time. **This is NOT a test for AIDS**. A positive test result does NOT indicate whether or not the person will get AIDS at some time in the future. It does **NOT** mean the person is immune to the virus. It **DOES** indicate that the person has been exposed to the virus, is assumed to have the virus in his/her body and could pass it on to others.

Negative Antibody Test

Usually it means that the person has not been infected with HIV.

TREATMENT

At this time there is no treatment which can repair the breakdown of the body's immune system. Treatments are available for many of the illnesses which develop because of the weakened immune system. However, AIDS is always fatal. Most patients die within three years of diagnosis.

PREVENTION

No vaccine is available in the foreseeable future. The only strategy to combat the spread of infection is to prevent the transmission of the virus from one person to another.

PUBLIC EDUCATION

GENERAL PUBLIC

Education of the general public is an essential component of the program to control AIDS and HIV infections. Knowledge of the routes of transmission and risk factors for infection should alleviate much of the unfounded concern which exists in the community. At the same time, correct information should motivate all individuals to realistically reduce their own risk of acquiring (or transmitting) this infection.

People infected with the virus may seem completely healthy and may not even know they have it. Although most persons in North America who are known to be infected are in high risk groups, **anyone** can become infected. Therefore, it is prudent for everyone to take precautions to protect themselves from becoming infected. The following information and advice is appropriate for all members of the general public:

- Infection through sexual contact can be avoided by practicing sexual abstinence or, for sexually active persons, by establishing a mutually exclusive relationship with an uninfected partner.
- Do not have sex with many different people. The more partners you have, the greater the chance of having sex with someone who is infected.
- Use condoms if there is any possibility your partner has been exposed to or is infected with HIV. A history of intravenous drug-use or of many sexual partners increases the chance that a person may have been infected.
- Do not share needles and syringes with anyone.
- Do not have anal intercourse. If you do have anal intercourse, use a condom.

SCHOOLS

School boards and public health units are encouraged to develop education programs to inform children, parents, and teachers about AIDS and HIV infections. Education about risk factors and risk reduction methods should be factual and non-judgmental.

SCHOOL AND COLLEGE AGED POPULATIONS

- Saying no to sex and drugs can virtually eliminate the risk of AIDS.
- Sexual transmission of HIV is not a threat to those uninfected individuals who practice responsible sexual behavior, based on fidelity, commitment and maturity, placing human sexuality within the context of an exclusive relationship.

RISK GROUPS/RISK ACTIVITIES

Persons in all the risk groups and persons who engage in risk activities should be informed about AIDS and HIV infections so they can minimize their risk of acquiring the infection and also minimize their risk of transmitting it.

If a person knows he/she is infected, precautions must be taken to prevent passing the virus on to another person. The following advice is particularly appropriate for persons who are in known risk groups or who engage in risk activities:

- Use condoms during sexual intercourse. The proper use of condoms may prevent infection with the virus carried in semen and vaginal fluid.
- Do not have anal intercourse. It can cause sores or cuts in the rectum and the virus may get into the bloodstream through these breaks. If you do have anal intercourse, use a condom.
- Do not have oral sex if you have open sores or cuts in the mouth.
- Do not allow semen, blood, urine or feces to enter the body of a sexual partner.
- Infected women should use a safe method of contraception to avoid pregnancy.
- Never share needles and syringes with anyone.
- Do not donate blood, organs or sperm.

CHANCROID

ETIOLOGY: *Haemophilus ducreyi*, the Ducrey bacillus.

CLINICAL: Single or multiple painful necrotizing ulcers, usually in the genital area, often associated with painful and/or suppurative regional lymph nodes.

Since many STDs cause genital ulcers, it is important to differentiate among them. All genital ulcers should be examined with darkfield microscopy.

INCUBATION PERIOD: From 3-5 days, up to 14 days.

COMMUNICABILITY: Until original lesion and/or discharging lymph nodes healed; usually several weeks.

DIAGNOSIS:

Identification of the organism in the exudate from the edges of the lesion, or from pus from buboes. Culture of this organism requires inoculation into special media, Thayer Martin plates and intrinsically supplemented chocolate agar. Laboratory staff should be consulted to optimize the culture of this organism.

TREATMENT:

Considerable variation occurs in antibiotic susceptibility patterns for *H. ducreyi*. Many strains are becoming resistant to sulfonamides. Although antibiotic resistance should be determined, one of the following regimens may be selected. Therapy should be continued for ten days.

1. *Sulfamethoxazole*, 800 mg/*trimethoprim*, 160 mg, by mouth, BID, for ten days. (A single dose of a sulfonamide 3200 mg/trimethoprim, 640 mg combination has also been shown to be as effective as ten days of therapy in the healing of ulcers and resolution of buboes.)

   OR

2. *Erythromycin*, 500 mg, PO, QID; for ten days.

FOLLOW-UP:

Follow-up schedules are individualized, but should be at no more than one week intervals until the lesion(s) are clearly resolving. Follow-up should continue until complete resolution has occurred. Patients should understand the importance of abstaining from sex while clinical disease is present.

EVALUATION OF SEX PARTNERS:

Current sex partners should receive a routine STD evaluation and be tested for and treated with a regimen adequate for chancroid.

NOTE: Chancroid is not endemic in Manitoba. Usually individuals have become infected outside of Canada.

OTHER SEXUALLY TRANSMISSIBLE DISEASES

Condylomata acuminata

Cytomegalovirus

Enteric infections

Granuloma inguinale

Hepatitis B

Herpes Genitalis

Lymphogranuloma venereum

Molluscum Contagiosum

Pediculosis

Scabies

Urethritis and mucopurulent cervicitis

CONDYLOMATA ACUMINATA (GENITAL WARTS)

DIAGNOSIS:

The human papilloma virus (HPV) which causes genital warts cannot be cultivated **in vitro**. A presumptive diagnosis is made on the basis of the typical clinical presentation. The diagnosis of condylomata lata should be excluded by obtaining a serologic test for syphilis.

Atypical or persistent warts should be biopsied since anogenital warts have been linked to the development of cancer.

VIRUS TYPING:

Females with genital warts should have a PAP smear. Specific HPV types are implicated in cervical cancer. Wart biopsies and/or cells from cervical scrapings may be submitted to Cadham Provincial Laboratory for virus typing. Specimens should be submitted in a 50 ml centrifuge tube containing 5 ml of phosphate-buffered saline. Contact Cadham Provincial Laboratory for information regarding containers and specimen transport.

TREATMENT:

Spontaneous regression commonly occurs in the absence of specific treatment. However, treatment is available and usually warranted. Procedures directed at individual lesions include:

1. *Podophyllin* 20-25% in tincture of benzoin applied topically by a clinician, which the patient washes off four to six hours later (contraindicated in pregnancy); or
2. Cryotherapy with liquid nitrogen; or
3. Electrodessication.

FOLLOW-UP:

Patients should return at one to two week intervals for retreatment until lesions have disappeared and the skin has healed. Patients should abstain from sexual contact or use condoms to prevent disease transmission until therapy is complete.

EVALUATION OF SEX PARTNERS:

Current sex partner(s) should have a routine STD evaluation. Any genital warts which are identified should be treated.

CYTOMEGALOVIRUS (CMV) INFECTION

ETIOLOGY: Cytomegalovirus — a member of the herpes virus family.

CLINICAL: Manifestations of **acquired** CMV infection may include pneumonia, mononucleosis syndrome, hemolytic anemia, splenomegaly, and petechial rash, but frequently no clinical symptoms are observed. The most frequent manifestations of **congenital** illness are hepatosplenomegaly, jaundice, purpura, microcephaly, cerebral calcifications, and choreoretinitis; deafness is one of the major problems associated with congenital CMV infection. Less specific findings in newborns are failure to thrive and recurrent respiratory infections.

DIAGNOSIS:

Isolation of the virus from urine, saliva, cervical secretions, breast milk or tissue in cell culture; by demonstration of "cytomegalic" cells in sediments of body fluids or in organs; by greater than or equal to a 4-fold rise in CMV titre in paired sera, and by demonstration of CMV — specific IgM.

TREATMENT:

Treatment is supportive, nonspecific, and symptomatic. Sexual abstinence or the use of condoms is indicated when clinical infection is present.

FOLLOW-UP:

Follow-up schedules are individualized according to clinical progress. The acquired illness is usually self-limited among immunocompetent individuals.

EVALUATION OF SEX PARTNERS:

Partners should be offered an STD evaluation.

Presently there is no specific therapy or vaccine to offer sex partners of patients with CMV infection.

ENTERIC INFECTIONS

A comprehensive review of the diagnosis and treatment of the sexually transmitted enteric infections is not possible here. However, awareness of the sexual transmission of these infections is crucial to the understanding of their epidemiology. Fecal-oral transmission is still thought to be the most common route of spread but there are obvious opportunities for sexual transmission to occur in some situations.

The sexually transmissible enteric pathogens include protozoa such as *Entamoeba histolytica* (amebiasis) and *Giardia lamblia* (giardiasis); viruses such as hepatitis A and B virus; and bacteria such as *shigella* sp, *Campylobacter jejuni*, and *salmonella* sp.

Because the field of enteric infections is large and complex, referring to the current medical literature is most important. Communicable Disease Control section can provide information on enteric infections.

DIAGNOSIS:

Definitive diagnosis depends upon specific identification of organisms. In some illnesses this is easy to accomplish. For instance, shigellosis and salmonellosis can be diagnosed by culturing a fresh stool specimen. Protozoa and helminths can be diagnosed by direct identification of ova, cysts, or trophozoites on microscopic examination, but a series of such examinations may be necessary. For some infections, a definitive diagnosis may be difficult to establish. For instance, *campylobacter* sp requires a specific culture medium and temperature. Hepatitis A is diagnosed on the basis of clinical findings and serology.

TREATMENT:

Most enteric infections do not require specific therapy. Fluid and electrolyte replacement for patients with diarrhea is, of course, important. Otherwise, treatment is dictated by the clinical status of the patient and microbiologic testing. For some infections, like hepatitis A, there is no specific therapy. For others, such as shigellosis, choice of therapy, when indicated, is dictated by sensitivity testing. Routes of administration and dosage are also determined by the clinical status of the patient.

FOLLOW-UP:

1. All patients with enteric infection should be educated about the modes of transmission of these pathogens and encouraged to modify or at least temporarily curtail behaviours which place them at risk for reinfection. As with all STDs, non-judgmental attitudes are vital to therapeutic success.
2. Following a course of therapy, several stool specimens should be examined for pathogens before cure can be reasonably well established. It may be difficult to distinguish reinfection from treatment failures. Additional therapy, educational efforts to modify sexual practices, and follow-up are indicated.

EVALUATION OF SEX PARTNERS:

Sex partners should be screened for STDs and any enteric pathogens to which they are exposed.

GRANULOMA INGUINALE (DONOVANOSIS)

ETIOLOGY: *Calymmatobacterium granulomatis*

CLINICAL: A nodule, vesicle, or papule becomes a slowly spreading, ulcerative process which extends peripherally with characteristic rolled edges. The process may result in extensive destruction.

DIAGNOSIS:

1. Definitive diagnosis is made when the causative organism, *Calymmatobacterium granulomatis*, is demonstrated by (a) direct smear or (b) culture.
2. The typical clinical presentation of single or multiple subcutaneous nodules at the site of inoculation which erode to form painless, beefy, granulomatous ulcers is sufficiently characteristic to establish a presumptive diagnosis among patients epidemiologically linked to definitive cases.

TREATMENT:

Tetracycline, 0.5 g, by mouth, QID for at least 21 days and preferably until all lesions have healed.

Erythromycin and sulfamethoxazole/trimethoprim regimens have also been reported to be effective. Penicillins are not effective.

FOLLOW-UP:

Follow-up schedules are individualized, but should be at no longer than weekly intervals until the lesion(s) are clearly resolving. Follow-up should continue until complete resolution has occurred. Patients should understand the importance of abstaining from sexual activity while any lesion is present.

EVALUATION OF SEX PARTNERS:

Current sex partners should receive a routine STD evaluation. A particular effort should be made to identify initial subcutaneous nodules, because early treatment decreases the likelihood of serious sequelae. All steady sex partners of cases should be treated prophylactically.

HEPATITIS B

ETIOLOGY: Hepatitis B virus — a 42 nm double-stranded DNA virus.

CLINICAL: Infection may be asymptomatic or associated with anorexia, nausea, vomiting, arthralgia, rash often progressing to jaundice. Fatality rate in hospitalized patients is about 1%. Prolonged hepatitis B antigenemia may ensue.

NOTE: There is evidence to suggest that hepatitis B, hepatitis A, and non-A non-B hepatitis all are sexually transmissible.

DIAGNOSIS:

The definitive diagnosis of hepatitis B requires that hepatitis B surface antigen (HBsAg) be detected in the serum of a patient in the acute phase of illness and that other types of acute hepatitis be excluded.

The diagnosis is presumptive in patients with the classic clinical syndrome and a positive HBsAg test.

The diagnosis is suggested when a patient with the classic clinical syndrome has an epidemiologic link with another definitive, presumptive, or suggestive case within the incubation period (45-180 days).

TREATMENT:

Treatment is non-specific, symptomatic, and supportive. It generally includes rest and adequate diet. Severe cases require hospitalization and, possibly, intravenous therapy to assure fluid and electrolyte balance. Fulminant progressive hepatitis B, although rare, may require exchange transfusions or other heroic measures.

FOLLOW-UP:

1. All cases should have the HBsAg test repeated 3 months and 6 months after diagnosis. Those who are positive at 6 months probably are chronic carriers and should be retested at 1 year. Those positive at 1 year are definitely chronic carriers and should be evaluated for infectivity with hepatitis B e antigen tests.
2. Infants born to HBsAg positive mothers should receive hepatitis prophylaxis (see communicable disease guidelines).

EVALUATION OF SEX PARTNERS:

1. Sex partners are at risk for developing hepatitis B, and sexual contact is contraindicated during the infectious period which may be prolonged.
2. Susceptible individuals at high-risk for acquiring hepatitis B may be protected from infection by vaccination (see communicable disease guidelines).

HERPES GENITALIS

ETIOLOGY: Herpes simplex virus (HSV): type II is a more frequent cause of genital herpes than type I.

CLINICAL: An incubation period of less than seven days is followed by a primary attack with multiple painful vesicles of the genital or perianal area. These ulcerate and crust and heal by three weeks. Viral shedding persists for only two weeks. Recurrences occur without the necessity for re-exposure and are less severe and of shorter duration. They may be precipitated by stress, intercourse, menstruation and other factors.

DIAGNOSIS:

A definitive diagnosis is made when a herpes simplex virus (HSV) is isolated in cell culture from scrapings taken from the base of a genital lesion. Lesions are commonly found on the cervix, vaginal walls, labia, urethra, penis, scrotum, rectum, thighs and buttocks.

Herpes genitalis is suspected whenever darkfield negative, typical herpetic genital lesions are present or a pattern of recurrence has developed.

TREATMENT:

1. First Clinical Episode: Oral acyclovir is best — five tablets per day for three-seven days. If the infection is severe (systemic) the patient may have to be hospitalized for IV acyclovir.
2. Recurring Disease: There is no effective treatment at present; oral acyclovir has shown promise in clinical trials.

Supportive therapy is directed at relieving pain, and keeping lesions clean and dry. Psychologic support is extremely important for these persons. They should be advised to abstain from all sexual activity until the lesions are completely healed. The use of condoms should be promoted.

The management of obstetrical and perinatal herpes simplex viral infections is beyond the scope of this manual but it should be recognized that infants born to mothers with active herpes at term are at considerable risk. Mothers with febrile illness near term should be examined carefully and cultures for HSV should be obtained from symptomatic sites. The screening of HSV from the cervix weekly throughout pregnancy has not been found to correlate with results at term for women with a previous history of HSV infection.

FOLLOW-UP:

Follow-up schedules are individualized according to clinical progress. Complete resolution of lesions without scarring is expected. Patients should understand that clinical recurrences are common and that abstaining from sexual intercourse during episodes of clinical infection is crucial. Women with genital herpes infection should be advised to have a yearly PAP test.

EVALUATION OF SEX PARTNERS:

1. Partners should be offered an STD evaluation.
2. They should only be tested specifically for HSV if lesions are present. Screening is not applicable in this illness.
3. Presently, there is no specific therapy or vaccine to offer sex partners of patients with genital herpes.

LYMPHOGRANULOMA VENEREUM (LGV)

ETIOLOGY: *Chlamydia trachomatis* of immunotypes L-1, L-2, and L-3.

CLINICAL: Small painless evanescent erosion, papule or nodule on the genital area. Regional lymph nodes suppurate and the inflammatory process spreads to adjacent tissues. In males, inguinal buboes may become adherent to skin and result in sinus formation. In the female, pelvic nodes may be involved and result in proctitis, stricture of the rectum and fistulas. Elephantiasis of the genitals may occur.

DIAGNOSIS:

1. Definitive diagnosis is based on the isolation of the causative organism, *Chlamydia trachomatis*, serotype L. The agent must be aspirated from an infected lymph node and grown in a cell or tissue culture.
2. The LGV complement fixation test (LGV-CFT) is sensitive and specific, and can be titred. A 4-fold rise in titre in a patient with the typical clinical syndrome constitutes a presumptive diagnosis.
3. The diagnosis is suggested by the typical clinical presentation and a single LGV-CFT with titre greater than 1:32.

TREATMENT:

1. Antimicrobials should be taken for at least fourteen days or until the adenopathy and lesions resolve.
   a. *Tetracycline*, 0.5 g, by mouth, QID for at least 2 weeks; or
   b. *Sulfisoxazole*, 4 g initially, then 0.5 g, by mouth, QID (other sulfonamides in analogous dosages may be used).
2. Fluctuant lymph nodes should be aspirated as needed, but not surgically removed.
3. Fistulae require surgical correction after the infection is cured.

FOLLOW-UP:

1. Clinical response is the best guage of therapy. Patients should be followed at one to two week intervals until all lesions have resolved. For some patients, this has required nine weeks of antibiotic therapy.
2. Since exacerbations of LGV are common, patients should be re-examined and have an LGV-CFT every three months for a year after therapy ends. Retreatment may be indicated by a rising titre.

EVALUATION OF SEX PARTNERS:

1. Sex partners of patients should be evaluated and treated as for LGV.
2. There are no proven methods of prevention of LGV. However, using condoms may prevent genital to genital or genital to rectal transmission.

MOLLUSCUM CONTAGIOSUM

ETIOLOGY: A human poxvirus.

CLINICAL: Pearly pink to white papules with a central pore. They are usually multiple and occur most frequently in the genital area in adults, and anywhere in children. The eruption usually clears spontaneously in six months.

DIAGNOSIS:

The poxvirus which causes molluscum contagiosum cannot be cultivated **in vitro**.

Most often, the disease is diagnosed presumptively on the basis of the typical clinical presentation.

A definitive diagnosis is made if virus-filled vacuoles, the molluscum inclusion bodies, are identified on microscopic examination of specially stained lesion material, or if poxviruses are seen by electron microscopic examination of material forwarded to the laboratory on a glass slide.

TREATMENT:

Lesions may resolve spontaneously without scarring. However, surgical or medical removal may be warranted. Procedures directed at individual lesions include:

1. Curettage after local cryoanesthesia; or
2. Application of cytotoxic substances (podophyllin or silver nitrate); or
3. Cryotherapy with liquid nitrogen.

FOLLOW-UP:

Patients should return at 1-2 week intervals until lesions have disappeared and the skin has healed.

EVALUATION OF SEX PARTNERS:

Current sex partner(s) should have a routine STD evaluation.

PEDICULOSIS (CRABS)

ETIOLOGY: *Phthirus pubis* — the crab louse.

CLINICAL: Severe itching and excoriation.

DIAGNOSIS:

1. Definitive diagnosis is made by finding lice or nits attached to genital hair.
2. Presumptive diagnosis is made when a patient with a history of recent exposure to pubic lice has pruritic erythematous macules, or papules on secondary excoriations in the genital region.
3. The diagnosis is suggested when the patient reports the finding of "crab" lice in the genital region. It is also suggested when the patient has been recently exposed to a definitive or presumptive case.

TREATMENT:

1. Several lotions, creams, or shampoos are effective. Application should be from mid-chest to mid-thigh.
   a. *Lindane*, 1% (lotion or cream), applied after warm shower or bath and left on for eight hours; or
   b. *Lindane*, 1% (shampoo), lathered on during a shower and left on for 4 minutes; or
   c. Pyrethrins with piperonyl butoxide which are left on for 10 mintues; or
   d. Tetrahydronaphthalene and copper oleate which is left on for 15 minutes.
2. These products must be thoroughly removed with soap and water.
3. Following treatment, comb out nits.
4. Clothing and linen should be disinfested by washing them in hot water, by dry cleaning them, or by removing them from human exposure for two weeks.

FOLLOW-UP:

Patients should be examined in one week. Since ova may survive, a second treatment may be necessary. Sexual or close physical contact should be avoided until after treatment. Patients should return if the problem is not cured or recurs.

EVALUATION OF SEX PARTNERS:

All sex partners should receive a routine STD evaluation.
Recent sex partners should be treated as recommended for pediculosis.

SCABIES

ETIOLOGY: *Sarcoptes scabiei* — a mite.

CLINICAL: Tiny papules or vesicles or tiny linear burrows. (Common sites of infection include the wrists, webbing between the fingers, the axillae, the penis and the inner thighs.) Intense itching is present, especially at night. Excoriations and secondary infection may occur.

DIAGNOSIS:

1. Definitive diagnosis requires that the mite, its eggs, larvae, or feces be identified grossly or microscopically. Specimens are obtained by scraping papules or burrows.
2. Presumptive diagnosis is made when a patient with or without a history of recent exposure to scabies has clinical evidence of infestation.

TREATMENT:

1. Several lotions or creams are effective. The selected product is applied to the entire skin surface from the neck down.
   a. *Lindane*, 1% (lotion or cream), is washed off with warm soapy water after eight hours; or
   b. Crotamiton, USP, is applied after a routine bath and again 24 hours later. A cleansing bath should be taken at 48 hours after the last application.
2. Clothing and linen should be disinfested by washing them in hot water, dry cleaning them, or by removing them from human exposure for two weeks.

FOLLOW-UP:

Patients should be examined in one week. Since ova may survive, a second treatment may be necessary. Sexual or close physical contact should be avoided until after treatment. Patients should return if the problem is not cured or recurs.

EVALUATION OF SEX PARTNERS:

All sex partners should receive a routine STD evaluation. Recent sexual partners should be treated as recommended for scabies.

URETHRITIS & MUCOPURULENT CERVICITIS

Urethritis is defined as a urethral inflammation which may be manifested as:

(i) history of urethral discharge and/or dysuria,

or

(ii) urethral discharge on examination,

or

(iii) 5 leukocytes per oil immersion field on microscopic examination of a urethral smear.

Mucopurulent cervicitis is defined as a cervical inflammation which may be manifested as:

(i) cervical ectopy with edema,

or

(ii) mucopurulent cervical discharge,

or

(iii) cervical bleeding on insertion of a swab,

or

(iv) 30 leukocytes per oil immersion field on a microscopic examination of cervical secretions (taken after the pus has been removed).

Urethritis in the male and mucopurulent cervicitis in the female can be caused by a number of different pathogens, primarily chlamydia and gonorrhea. Although laboratory testing to define the etiologic agent is ideal, testing (e.g. antigen detection for chlamydia) may not always be readily available.

The following algorithm suggests an approach to the management of patients with urethritis/cervicitis.

Please note that contact tracing by Public Health nurses is initiated only for contacts of confirmed cases of gonorrhea and chlamydia and **not** for non-specific urethritis and cervicitis. The management of cases of gonorrhea and chlamydia and of their contacts is outlined in the sections on these specific diseases.

Patients with urethritis or muco purulent cervicitis should be advised to inform their own partners of their risk.

MALE

Urethritis

↓

History & Examination

↓

Urethral Smear For Gram Stain

Positive or not available	Negative with leukocytes 5*
↙	↘
1. Culture for Gonorrhea	1. Culture for Gonorrhea
+	+
2. Antigen detection, microtrak or chlamydiazyme for Chlamydia	2. Antigen detection, microtrak, or chlamydiazyme for Chlamydia
↓	↓
Treatment	Treatment
1. *Ampicillin* 3.5 gm. p.o. or *Aqueous Procaine Penicillin G* 4.8 million units IM	1. *Tetracycline* 500 mg. p.o. QID × 7 days
+	
2. *Probenecid* 1.0 gm. p.o.	
+	
3. *Tetracycline* 500 mg. p.o. QID × 7 days	

1. Test of Cure — disease specific — i.e. at 3-5 days after completion of therapy for gonorrhea and at 4 weeks after completion of therapy for chlamydia for high-risk cases, e.g. repeaters, PID.
2. Contact tracing if laboratory-confirmed gonorrhea and/or chlamydia to follow guidelines for specific disease.

* If five leukocytes are present per oil immersion field, it may be reasonable to attempt chlamydia detection, but in most cases results will be negative.

FEMALE

Mucopurulent Cervicitis/Pelvic Inflammatory Disease

↓

History & Examination

↓

Endocervical Smear For Gram Stain

1. Culture for Gonorrhea
2. Antigen detection, microtrak or Chlamydiazyme for Chlamydia

Treatment

1. *Ampicillin* 3.5 gm. p.o.
   or
   Aqueous Procaine Penicillin G 4.8 million units I.M.
   +
2. *Probenecid* 1.0 gm. p.o.
   +
3. *Tetracycline* 500 mg. p.o. QID for 7-14 days*

1. Test of Cure — disease specific — i.e. at 3-5 days after completion of therapy for gonorrhea, and at 4 weeks after completion of therapy for chlamydia but is **recommended only for high-risk cases**, e.g. repeaters, PID.
2. Contact tracing if laboratory-confirmed gonorrhea and/or chlamydia to follow guidelines for specific diseases.

* Mucopurulent Cervicitis — 7 days
PID — 10-14 days

APPENDIX A

Revised Regulation P210/R2

DIVISION II

being a Regulation under

Chapter P210

THE PUBLIC HEALTH ACT

Respecting Sexually Transmitted Disease

OFFICE CONSOLIDATION

NOTICE

All persons making use of this consolidation are reminded that it has no legislative sanction; that the amendments have been embodied only for convenience of reference; and that the original Regulation should be consulted for all purposes of interpreting and applying the law.

Printed by the Queen's Printer for the Province of Manitoba

THE PUBLIC HEALTH ACT
(C.C.S.M. c. P210)

MANITOBA REGULATION 338/88 R

DISEASES AND DEAD BODIES REGULATION

NOTICE
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Printed by the Queen's Printer for the Province of Manitoba

"Également Disponible en Français"

THE PUBLIC HEALTH ACT
(C.C.S.M. c. P210)

Diseases and Dead Bodies Regulation

Regulation 338/88 R
Filed August 29, 1988

Definitions
1 In this regulation,

"director" means the Director of Communicable Disease Control or the designate of that Director; ("directeur")

"health officer", "medical officer of health", "medical health officer" or "medical officer" means the person who, under The Public Health Act, or The Health Services Act is, or is appointed as, a medical officer of health or medical director of a local health unit. ("hygiéniste", "médecin hygiéniste", "agent sanitaire" ou "médecin")

PART I
DISEASE CONTROL

Definitions
2 In this Part,

"carrier" means a person who harbours a specific infectious agent in the absence of discernible illness and serves as a potential source of infection to others; ("porteur")

"communicable disease", "contagious disease", or "infectious disease" means an illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from a reservoir to a susceptible host either directly as from an infected person or animal, or indirectly through the agency of an intermediate plant or animal host, a vector, or the inanimate environment; ("maladie contagieuse" ou "maladie infectieuse")

"concurrent disinfection" means disinfection during the continuance of the illness of a patient; ("désinfection concomitante")

LOI SUR LA SANTÉ PUBLIQUE
(C.P.L.M., c. P210)

Règlement sur les maladies et les dépouilles mortelles

Règlement 338/88 R
Date de dépôt : le 29 août 1988

Définitions
1 Les définitions qui suivent s'appliquent au présent règlement.

"directeur" Le directeur du Contrôle des maladies contagieuses ou son représentant. ("director")

"hygiéniste", "médecin hygiéniste", "agent sanitaire" ou "médecin" Personne qui, en vertu de la Loi sur la santé publique ou de la Loi sur les services de la santé, est médecin hygiéniste ou directeur d'une unité sanitaire locale, ou est nommé à ce titre. ("health officer", "medical officer of health", "medical health officer" or "medical officer")

PARTIE I
CONTRÔLE DES MALADIES

2 Les définitions qui suivent s'appliquent à la présente partie.

"animal domestique" Tout oiseau ou animal domestiqué et qui est :
a) soit gardé pour le plaisir;
b) soit offert en vente pour être gardé comme animal domestique. ("pet")

"contact" Personne ou animal qui a été suffisamment près d'une personne ou d'un animal infecté ou du milieu contaminé par cette personne ou cet animal pour avoir été exposé au transfert de matière infectieuse, soit directement de la personne ou de l'animal, soit indirectement par le milieu. ("contact")

"désinfection" Destruction de micro-organismes pathogènes à l'extérieur du corps par application directe de procédés chimiques, physiques ou autres. ("disinfection")

"désinfection concomitante" Désinfection pendant la durée de la maladie d'un patient. ("concurrent disinfection")

"contact" means a person or animal who or which has been sufficiently near to an infected person or animal or the environment contaminated by the person or animal, so as to have been exposed to transfer of infectious material either directly from the person or animal or indirectly from the environment; ("contact")

"director" means the Director or, in his or her absence, the Assistant Director, of Communicable Disease Control of the department; ("directeur")

"disinfection" means the destruction of pathogenic microorganisms outside the body by chemical, physical or other means, directly applied; ("désinfection")

"disinfestation" means any physical or chemical process that destroys or removes undesired small animal forms, particularly arthropods or rodents; ("désinsectisation")

"immune" means a person or animal who or which, by virtue of previous infection or immunization, possesses protective antibodies against a specified communicable disease and therefore is unlikely to be susceptible to it; ("immunisé")

"infectious tuberculosis" means any form of tuberculosis in which the tubercle bacillus can be demonstrated in the sputum or any other bodily secretion, excretion, or discharge, including discharge from open or discharging wounds or where there is any other evidence to support the fact that the disease is in an infectious state; ("tuberculose infectieuse")

"infection" means the entry and development or multiplication of an infectious agent in the body of a person or animal, with or without clinical manifestations; ("infection")

"inspector", "sanitary inspector", or "public health inspector" means a public health inspector appointed under The Public Health Act or The Department of Health Act; ("inspecteur", "inspecteur sanitaire" ou "inspecteur d'hygiène publique")

"isolation" means the separation, for the period of communicability, of infected persons or animals from others in such places and under such conditions as to prevent the direct or indirect conveyance of the infectious agent from those infected to those who are susceptible or who may spread the agent to others; ("isolement")

"notifiable disease" means cancer or malignant tumor or any of the communicable diseases listed in sections 3, 4, 5 and 6; ("maladie à déclarer")

"pet" means any bird or animal that is domesticated and is
(a) kept for pleasure, or
(b) offered for sale to be kept as a pet;
("animal domestique")

"désinfection terminale" Désinfection des effets personnels et du milieu d'un patient dans les cas suivants :
a) après la guérison du patient;
b) au terme de la période d'isolement;
c) après le retrait du patient du milieu;
d) après que le patient a cessé d'utiliser ces effets. ("terminal disinfection")

"désinsectisation" Procédé physique ou chimique qui détruit ou élimine les petites formes animales indésirables, notamment les arthropodes ou les rongeurs. ("disinfestation")

"directeur" Le directeur des Services médicaux de prévention du ministère ou, en son absence, l'épidémiologiste adjoint. ("director")

"immunisé" Personne ou animal qui, par suite d'une infection antérieure ou d'une immunisation, possède des anticorps protecteurs contre une maladie contagieuse déterminée et est par conséquent peu susceptible d'y être réceptif. ("immune")

"infection" Pénétration et développement ou multiplication d'un agent infectieux dans le corps d'une personne ou d'un animal, avec ou sans manifestations cliniques. ("infection")

"isolement" Mise à l'écart, pendant la période de contagion, de personnes ou d'animaux infectés, dans des endroits et des conditions adéquates afin de prévenir le transport direct ou indirect de l'agent infectieux des personnes ou animaux infectés aux personnes ou animaux qui y sont réceptifs ou qui sont susceptibles de le propager. ("isolation")

"inspecteur", "inspecteur sanitaire" ou "inspecteur d'hygiène publique" Inspecteur d'hygiène publique nommé en vertu de la Loi sur la santé publique ou de la Loi sur le ministère de la santé. ("inspector", "sanitary inspector" or "public health inspector")

"maladie contagieuse" ou "maladie infectieuse" Maladie causée par un agent infectieux déterminé ou ses produits toxiques, qui résulte de la transmission de cet agent ou de ses produits à partir d'un réservoir à un hôte réceptif, soit directement à partir d'une personne ou d'un animal infecté, soit indirectement par l'intermédiaire d'une plante ou d'un animal hôte, d'un vecteur ou du milieu inanimé. ("communicable disease", "contagious disease", or "infectious disease")

"maladie à déclarer" Cancer, tumeur maligne ou l'une ou l'autre des maladies contagieuses énumérées aux articles 3, 4, 5 et 6. ("notifiable disease")

"porteur" Personne qui, en l'absence de maladie visible, porte en elle un agent infectieux déterminé et constitue une source potentielle d'infection pour les autres. ("carrier")

"quarantine" means
(a) in respect of a person or animal, the restriction of freedom of movement of any person or animal who or that has been exposed to a communicable disease for a period of time equal to the longest usual incubation period of the disease or for as long as the person or animal gives evidence of harbouring the infectious agent, in such manner as to prevent effective contact with any person or animal not so exposed, and ;
(b) in respect of premises or a part of any premises, the prohibition against or the restriction of entering or leaving the premises or part by any person; ("quarantaine")

"terminal disinfection" means the disinfection of the personal effects of a patient and the environment of the patient
(a) after the recovery of the patient,
(b) after the termination of a period of isolation,
(c) after the removal of the patient from the environment, or
(d) after the patient has ceased to use those effects. ("désinfection terminale")

Reportable diseases
3 The following diseases shall be reported to the director on Form 1 of Schedule A and those identified by an asterisk (*) shall also be reported to the director as soon as possible by telephone or similar rapid means of communication:
(a) INTESTINAL INFECTIOUS DISEASES
* Typhoid fever
Paratyphoid fever
Salmonellosis
Shigellosis
* Food poisoning (bacterial)
(excluding Botulism
Salmonellosis, Shigellosis)
Staphylococcal
Clostridium perfringens
Other Clostridia
Vibrio parahaemolyticus
Bacillus cereus
Unspecified
E. coli Enteritis

(b) TUBERCULOSIS
A. Primary Tuberculosis
B. Bacteriologically Confirmed
1. Respiratory
2. Non-Respiratory
C. Not Bacteriologically Confirmed
1. Respiratory
2. Non-Respiratory

"quarantaine" S'entend :
a) dans le cas de personnes ou d'animaux, de la restriction de la liberté de déplacement d'une personne ou d'un animal qui a été exposé à une maladie contagieuse, restriction appliquée, d'une part, pendant une période égale à la plus longue période d'incubation normale de la maladie ou tant que la personne ou l'animal donne des preuves de la présence dans leur organisme de l'agent infectieux, et d'autre part, de manière à prévenir tout contact effectif avec quelque autre personne ou animal non exposé;
b) dans le cas de locaux ou de partie de locaux, de l'interdiction ou des restrictions imposées à une personne quant à son droit d'entrer dans des locaux ou une partie de ceux-ci, ou d'en sortir. ("quarantine")

"tuberculose infectieuse" Toute forme de tuberculose dans laquelle le bacille tuberculeux peut être identifié dans le crachat ou dans toute autre sécrétion, excrétion ou perte, y compris les pertes provenant de plaies ouvertes ou suppuratives, ou lorsqu'il existe quelque autre preuve que la maladie est infectieuse. ("infectious tuberculosis")

Maladies à signaler
3 Les maladies suivantes doivent être signalées au directeur au moyen de la formule 1 de l'annexe A. Les maladies précédées d'un astérisque (*) doivent de plus être signalées aussitôt que possible au directeur soit par téléphone soit par un autre moyen rapide de communication :
a) MALADIES INFECTIEUSES INTESTINALES
* Fièvre typhoïde
Fièvre paratyphoïde
Salmonellose
Shigellose
* Toxi-infection alimentaire (bactérienne)
(sauf le botulisme, la salmonellose, la shigellose)
à staphylocoques
à Clostridium perfringens
à d'autres Clostridia
à Vibrio parahaemolyticus
à Bacillus cereus
sans précision
Entérites à E. coli

b) TUBERCULOSES
A. Tuberculose primaire
B. Confirmée bactériologiquement
1. Respiratoire
2. Non respiratoire
C. Non confirmée bactériologiquement
1. Respiratoire
2. Non respiratoire

(c) DISEASES OF CENTRAL NERVOUS SYSTEM
Meningitis
A. Bacterial
Haemophilus
Pneumococcal
Other (All categories excluding Meningoccoccal and Tuberculosis)
B. Viral
Aseptic Meningitis due to
Coxsackie virus
Echo virus
Other viral
Encephalitis
Western Equine encephalitis
Other viral encephalitis (specify)

(d) OTHER BACTERIAL DISEASES
* Diphtheria Cases
Diphtheria Carriers
* Meningococcal infections
Pertussis
Brucellosis

(e) OTHER VIRAL DISEASES
Hepatitis A
Hepatitis B
Measles
Rubella
Congenital Rubella
Mumps

4(1) The following diseases shall be reported to the director on Form 2 of Schedule A and those indicated by an asterisk (*) shall also be reported to the director by telephone or other rapid means of communication:
Amoebiasis
* Anthrax
Brucellosis
* Cholera
* Lassa Fever
Leprosy
Malaria
* Plague
* Poliomyelitis
Psittacosis
* Rabies
Tetanus
Trichinosis
Tularaemia
* Viral Haemorrhagic fever
Yellow Fever

4(2) The following diseases shall be reported to the director on Form 2 of Schedule A only when they occur in large numbers or epidemic proportions in a community, and the report shall state either the number of cases or the percentage of population having the disease:
Chickenpox
Influenza
Skin diseases, communicable.
(a) Impetigo;
(b) Pediculosis;
(c) Ringworm;
(d) Scabies;

c) MALADIES DU SYSTÈME NERVEUX CENTRAL
Méningite
A. Bactérienne
à Haemophilus
à pneumocoques
Due à d'autres maladies bactériennes (Toutes les catégories sauf à méningocoques et tuberculeuse)
B. Virale
Méningite aseptique due :
au virus de Coxsachie
au virus ECHO
autres méningites virales
Encéphalites
Virus de l'encéphalite équine occidentale
Autres encéphalites virales

d) AUTRES MALADIES BACTÉRIENNES
Brucellose
* Cas de diphtérie
Coqueluche
* Infections à méningocoques
Porteurs de diphtérie

e) AUTRES MALADIES VIRALES
Hépatite A
Hépatite B
Oreillons
Rougeole
Rubéole
Rubéole congénitale

4(1) Les maladies suivantes doivent être signalées au directeur au moyen de la formule 2 de l'annexe A. Les maladies précédées d'un astérisque (*) doivent de plus être signalées soit par téléphone soit par un autre moyen rapide de communication :
Amibiase
Brucellose
* Charbon bactérien
* Choléra
* Fièvre de Lassa
Fièvre jaune
* Fièvre virale hémorragique
Lèpre
Malaria
* Peste
* Poliomyélite
Psittacose
* Rage
Tétanos
Trichinose
Tularémie

4(2) Les maladies suivantes ne doivent être signalées au directeur, au moyen de la formule 2 de l'annexe A, que si on en dénombre un grand nombre de cas ou si elles prennent des proportions épidémiques dans une communauté. Le rapport doit faire état du nombre de cas ou du pourcentage de la population qui est atteint de la maladie :
Grippe
Maladies de la peau contagieuses :
a) impétigo
b) pédiculose
c) teigne tonsurante
d) gale
Varicelle

Other diseases occurring in large numbers or epidemic proportions and which appear to a duly qualified medical practitioner to be communicable.

5 In addition to individual reports required under section 3, subsection 4(1) and section 6, the person in charge of a laboratory shall report to the director the numbers of persons with microscopic, culture, immunologic, serologic or other evidence of any of the following diseases:

Arboviral infection, including St. Louis Encephalitis and Dengue
Brucellosis
Campylobacter infection
Giardiasis
Human Immunodeficiency Virus Infection
Influenza
Legionnaire's Disease
Parasitic diseases not otherwise specified
Q fever
Relapsing fever
Rickettsial Diseases, other
Rocky Mountain Spotted fever
Rotavirus infections
Streptococcal (B-Haemolytic) infection
Yersinia infections

6 The following sexually transmitted diseases and the contacts of persons with those diseases identified by an asterisk (*) in the list below shall be reported as required in Part II of this regulation:

* Gonorrhea
* Syphilis
* Chancroid
* Chlamydia
Acquired immunodeficiency syndrome (AIDS)

7 Cancer and malignant neoplasms shall be reported on Form 3 of Schedule A.

Reporting of diseases by doctors, hospitals and laboratories

8(1) On becoming aware that any person is suffering from a notifiable disease, or any other disease that may be dangerous to the public health, a duly qualified medical practitioner shall forthwith report particulars of the case as required in section 3, 4, 5, 6 or 7 to

(a) the medical officer of health of the municipality in which the patient resides; or
(b) the director, if the patient resides in an area in which there is no medical officer of health.

Autres maladies dont on dénombre un grand nombre de cas ou qui prennent des proportions épidémiques, et qu'un médecin considère contagieuses.

5 En plus des rapports individuels exigés à l'article 3, au paragraphe 4(1) et à l'article 6, les personnes qui sont en charge de laboratoires sont tenues de signaler au directeur le nombre de personnes qui présentent les symptômes de l'une des maladies énumérées ci-après, qu'il s'agisse de symptômes de nature microscopique, immunologique, sérologique ou autre ou apparaissant dans une culture :

Autres rickettsioses
Brucellose
Fièvre du Queensland
Fièvre pourprée des Montagnes Rocheuses
Fièvre récurrente
Giardiase
Grippe
Infection à campylobactère
Infection arbovirale, y compris l'encéphalite de St-Louis et la dengue
Infection à rotavirus
Infection à streptocoques (Hémolitique B)
Infection à yersinia
Infection au virus de l'immunodéficience humaine (VIH)
Maladie du légionnaire
Maladies parasitaires non spécifiées autrement

6 Les maladies à transmission sexuelle énumérées ci-après, de même que les contacts de personnes atteintes des maladies précédées d'un astérisque (*) doivent être signalés conformément à la partie II du présent règlement :

* Gonorrhée
* Syphilis
* Chancre mou
* Chlamydia
Syndrome d'immuno-déficience acquise (SIDA)

7 Les cancers et les tumeurs malignes doivent être signalés au moyen de la formule 3 de l'annexe A.

Rapport relatif aux maladies par les médecins, les hôpitaux et les laboratoires

8(1) Le médecin qui découvre qu'une personne est atteinte d'une maladie à déclarer ou de quelque autre maladie susceptible de représenter un danger pour la santé publique, doit présenter sans tarder un rapport faisant état du détail du cas conformément à l'article 3, 4, 5, 6 ou 7 :

a) soit au médecin hygiéniste de la municipalité où réside le patient;
b) soit au directeur, si le patient réside dans une région où il n'y a pas de médecin hygiéniste.

8(2) The superintendent or other person in charge of every hospital shall submit to the director, monthly, on Form 4 of Schedule A, a report of patients treated in the hospital for any communicable disease including those listed in sections 3, 4, 5 and 6 and including rheumatic fever and poststreptococcal glomerulonephritis.

8(3) Every person in charge of a clinical laboratory who in the examination of any specimen derived from a human body finds microscopical, cultured, immunological, serological or other evidence of a notifiable disease listed in section 3, 5 or 6, or in subsection 4(1) shall within seven days report the nature of that evidence to the director together with the name and address of the person from whom the specimen was taken and the name and address of the duly qualified medical practitioner, if any, who is, or has been, attending the person from whom the specimen was taken.

8(4) The person in charge of a laboratory shall, upon the request of the medical officer of health or director, provide the name, residence address, sex and age of each person included in a report submitted under section 5.

Reporting of deaths by doctors and hospitals

9(1) Every duly qualified medical practitioner treating a patient who dies from a notifiable disease shall forthwith report the death to the medical officer of health and the director on Form 5 of Schedule A.

9(2) Where a person suffering from a notifiable disease dies in any hospital, the superintendent or other person in charge of the hospital shall forthwith report the death to the medical officer of health and the director on Form 5 of Schedule A.

Reporting biopsies or autopsies

10 Every person who, in performing a biopsy or autopsy, discovers evidence of a notifiable disease, shall report the nature of that evidence to the director, together with the name and address of the person on whom the autopsy was made, or from whom the tissue was taken, and the name and address of the duly qualified medical practitioner, if any, who is, or had been, attending the person on whom the autopsy was made or from whom the tissue was taken.

Director may furnish information

11 The director may furnish information respecting a notifiable disease to any organization or institution that is carrying on research in respect of that notifiable disease.

Examination of persons and premises

12(1) Upon receiving a report under subsection 8(1), a medical officer of health or the director, as the case may be, may examine, or cause an examination to be made of, the person suspected of having the disease or inspect, or cause an inspection to be made of, the institution or premises in which the person resides or attends.

8(2) Le surintendant ou toute autre personne responsable d'un hôpital transmet chaque mois au directeur, au moyen de la formule 4 de l'annexe A, un rapport indiquant le nom des patients traités à l'hôpital pour une maladie contagieuse, y compris une maladie contagieuse visée aux articles 3, 4, 5 et 6 ainsi que le rhumatisme articulaire aigu et le glomérulonéphrite post-streptococcique.

8(3) Le responsable d'un laboratoire clinique qui, lors de l'examen d'un spécimen provenant d'un corps humain, découvre une preuve révélant la présence d'une maladie à déclarer visée à l'article 3, 5 ou 6 ou au paragraphe 4(1), qu'il s'agisse d'une preuve de nature microscopique, immunologique, sérologique ou autre, ou que celle-ci apparaisse dans une culture, est tenu de présenter au directeur, dans les sept jours, un rapport indiquant la nature de cette preuve, le nom et l'adresse de la personne de qui provient le spécimen, ainsi que le nom et l'adresse, s'il y a lieu, du médecin traitant de cette personne.

8(4) Sur demande du médecin hygiéniste ou du directeur, le responsable d'un laboratoire indique le nom, l'adresse résidentielle, ainsi que le sexe et l'âge de chaque personne mentionnée dans un rapport soumis conformément à l'article 5.

Rapport concernant les décès par les médecins et les hôpitaux

9(1) Le médecin traitant un patient qui meurt d'une maladie à déclarer signale sans tarder ce décès au médecin hygiéniste et au directeur au moyen de la formule 5 de l'annexe A.

9(2) Lorsqu'une personne souffrant d'une maladie à déclarer meurt dans un hôpital, le surintendant ou toute autre personne responsable de l'hôpital signale sans tarder ce décès au médecin hygiéniste et au directeur au moyen de la formule 5 de l'annexe A.

Rapport concernant les biopsies et les autopsies

10 La personne qui, en pratiquant une biopsie ou une autopsie, découvre une preuve révélant la présence d'une maladie à déclarer, est tenue de présenter au directeur un rapport indiquant la nature de la preuve, le nom et l'adresse de la personne sur laquelle l'autopsie a été pratiquée ou le tissu prélevé, et, s'il y a lieu, le nom du médecin traitant de cette personne.

Renseignements divulgués par le directeur

11 Le directeur peut fournir aux organisations ou établissements qui effectuent des recherches sur une maladie à déclarer des renseignements concernant cette maladie.

Examen des personnes et des locaux

12(1) Sur réception d'un rapport présenté en application du paragraphe 8(1), un médecin hygiéniste ou le directeur, selon le cas, peut examiner ou faire examiner la personne soupçonnée d'être atteinte de la maladie ou encore inspecter ou faire inspecter l'établissement ou les locaux que cette personne habite ou fréquente.

12(2) Any person being examined, or any person in an institution or premises being inspected, under subsection (1) shall give to the medical officer of health or anyone delegated by the medical officer of health to make the examination or inspection, all information of which that person has knowledge, including

(a) the source of infection or contagion of the disease or the suspected source;
(b) the occupation of all persons residing in, working in or visiting, the premises;
(c) the facilities available for isolating the person having, or infected by, the disease; and
(d) such other information as the medical officer of health or the person making the examination or inspection may require.

Powers of the medical officer of health, director and minister

13(1) Where a medical officer of health has reason to believe that a person residing in a house or locality within his or her jurisdiction, has a notifiable disease or any other disease dangerous to the public health, the medical officer of health may examine the person or cause the person to be examined, or may inspect the house or locality, or cause it to be inspected.

13(2) Subsection 12(2) applies, with such modifications as the circumstances require, to an examination under subsection (1) of this section.

13(3) Where the director, or if the person is within the jurisdiction of a medical health officer, a medical health officer, has reason to believe that a person has a notifiable disease or other disease dangerous to the public health, the director or medical health officer, as the case may be, may, in his or her absolute discretion,

(a) order the person to be admitted to a hospital;
(b) order the person to be isolated;
(c) order the person or any other person exposed to the infection or both, to be quarantined; or
(d) order the premises in which the person resides to be quarantined;

or may take any one or more of the actions set out in clauses (a), (b) (c), and (d).

13(4) The minister, at the request of the director, for the purpose of preventing, mitigating, or suppressing disease, or reducing exposure of the public to a communicable disease, may order the physical examination, including X-ray examination, of any person or group of persons.

Hospitalization

14(1) The director may order that a person who is suffering from a notifiable disease and who has been admitted to a hospital shall not leave the hospital without the consent of the director.

12(2) Les personnes qui sont examinées, ou celles qui se trouvent dans l'établissement ou les locaux inspectés conformément au paragraphe (1), révèlent au médecin hygiéniste ou à la personne déléguée par ce dernier pour procéder à l'examen ou à l'inspection, tous les renseignements dont elles ont connaissance, y compris :

a) la source connue ou soupçonnée de l'infection ou de la contagion de la maladie;
b) le métier ou la profession des personnes qui résident dans les locaux, qui y travaillent ou qui les visitent;
c) les installations disponibles aux fins de l'isolement de la personne qui est atteinte de la maladie ou infectée par celle-ci;
d) tout autre renseignement exigé par le médecin hygiéniste ou la personne procédant à l'examen ou à l'inspection.

Pouvoirs du médecin hygiéniste, du directeur et du ministre

13(1) Le médecin hygiéniste qui a des raisons de croire qu'une personne résidant dans une maison ou une localité relevant de sa compétence est atteinte d'une maladie à déclarer ou de quelque autre maladie dangereuse pour la santé publique, peut examiner ou faire examiner cette personne ou inspecter ou faire inspecter cette maison ou cette localité.

13(2) Le paragraphe 12(2) s'applique, compte tenu des adaptations de circonstance, aux examens prévus au présent article.

13(3) Lorsque le directeur, ou un médecin hygiéniste si le cas relève de la compétence d'un médecin hygiéniste, a des raisons de croire qu'une personne est atteinte d'une maladie contagieuse ou de quelque maladie dangereuse pour la santé publique, le directeur ou le médecin hygiéniste a entière discrétion pour prendre l'une ou plusieurs des mesures suivantes :

a) ordonner l'admission de la personne dans un hôpital;
b) ordonner l'isolement de la personne
c) ordonner la mise en quarantaine de la personne en question, de toute autre personne exposée à l'infection, ou des deux;
d) ordonner la mise en quarantaine des locaux dans lesquels la personne réside.

13(4) Le ministre peut, sur demande à cet effet du directeur, ordonner qu'une personne ou un groupe de personnes subisse un examen médical, y compris des examens radiographiques, dans le but de prévenir une maladie, d'en mitiger les effets ou de l'éliminer, ou encore de réduire l'exposition du public à une maladie contagieuse.

Hospitalisation

14(1) Le directeur peut ordonner qu'une personne atteinte d'une maladie à déclarer, qui a été admise dans un hôpital, ne puisse quitter l'hôpital sans le consentement du directeur.

14(2) Where a person leaves a hospital in contravention of subsection (1), the superintendent or person in charge of the hospital shall notify the director immediately.

Quarantined premises
15(1) Subject to subsection (3), where the director or a medical officer of health has ordered a premises to be quarantined under subsection 13(3), he or she may place, or cause to be placed, a placard on each outer door of the premises.

15(2) The placard referred to in subsection (1) shall have printed on it, in large letters, a statement that entrance to or exit from the premises without the permission of the director or the medical officer of health is prohibited.

15(3) Where a communicable disease is reported or known to exist in a tenement house or apartment building and if the director or the medical officer of health orders the premises quarantined in respect thereof, the order may apply only to the room or apartment in which the diseased person resides, in which case the placard shall be placed on or near the door of the room or apartment.

15(4) If the director or the medical officer of health deems it necessary, an additional placard may be placed on the street entrance door of the tenement house or apartment building, which placard shall, in addition to the statement required by subsection (2), have printed on it in large letters the room or apartment number in which the diseased person resides and that the quarantine applies only to that room or apartment.

15(5) No person other than a duly qualified medical practitioner or registered nurse shall enter or leave premises under quarantine unless that person has the permission of the medical officer of health.

Leaving isolation or quarantine
16(1) The medical officer of health may order that no person who has been isolated shall leave the room or dwelling in which he or she has been isolated without the permission of the medical officer of health.

16(2) Without the permission of the medical officer of health, no person shall remove, or cause to be removed, a person who has been isolated from the room or dwelling within which he or she has been isolated.

16(3) The period of any order of quarantine or isolation made under the Act or the regulations shall not be abridged or terminated except under the authority of the person who made the order.

Quarantine for refusal to be examined
17 Any person, whom the director or a medical officer of health has reasonable grounds to believe is or has been exposed to, or is suffering from, a communicable disease and who

14(2) Si une personne quitte l'hôpital en contravention du paragraphe (1), le surintendant ou la personne responsable de l'hôpital en avise immédiatement le directeur.

Locaux mis en quarantaine
15(1) Sous réserve du paragraphe (3), le directeur ou le médecin hygiéniste qui a ordonné la mise en quarantaine de locaux en application du paragraphe 13(3) peut installer ou faire installer une affiche sur chaque porte extérieure des locaux.

15(2) L'affiche mentionnée au paragraphe (1) doit comporter une mention, imprimée en grosse lettres, indiquant qu'il est interdit d'entrer dans les locaux ou d'en sortir sans la permission du directeur ou du médecin hygiéniste.

15(3) Si l'existence d'une maladie contagieuse dans une maison de rapport ou un immeuble d'appartements est signalée ou connue, et que le directeur ou le médecin hygiéniste ordonne la mise en quarantaine des locaux relativement à cette maladie contagieuse, il peut ordonner que seule la chambre ou le logement où réside la personne malade soit mis en quarantaine, auquel cas, l'affiche doit être installée sur la porte de la chambre ou de l'appartement ou à proximité de celle-ci.

15(4) Si le directeur ou le médecin hygiéniste estime la chose nécessaire, une affiche additionnelle peut être installée sur la porte d'entrée donnant sur la rue de la maison de rapport ou de l'immeuble d'appartements, auquel cas l'affiche doit comporter, imprimés en gros caractères, outre la mention exigée au paragraphe (2), le numéro de la chambre ou du logement où réside la personne malade et le fait que la mise en quarantaine ne s'applique qu'à cette chambre ou à cet appartement.

15(5) Exception faite des médecins ou des infirmières, seules les personnes autorisées par le médecin hygiéniste peuvent entrer dans des locaux mis en quarantaine ou en sortir.

Autorisation de quitter l'isolement ou la mise en quarantaine
16(1) Le médecin hygiéniste peut ordonner qu'il soit interdit à toute personne isolée de quitter sans son autorisation la chambre ou le logement où elle a été isolée.

16(2) Nul ne peut, sans l'autorisation du médecin hygiéniste, retirer ou faire retirer une personne qui a été isolée de la chambre ou du logement où elle a été isolée.

16(3) La durée d'un ordre de mise en quarantaine ou d'isolement pris en application de la Loi ou des règlements ne peut être écourtée ou déclarée terminée que sous l'autorité de la personne qui a pris cet ordre.

Mise en quarantaine pour refus de subir un examen
17 Les personnes à l'égard desquelles le directeur ou un médecin hygiéniste a des motifs raisonnables de croire qu'elles sont ou ont été exposées à une maladie contagieuse, ou qu'elles

fails to submit to an examination as required by an order issued under the Act or the regulations, may be quarantined in his or her own home by the director or medical officer of health for such time as is necessary to enable the director or the medical officer of health to satisfy himself or herself that the person is not suffering from a communicable disease.

Measures to prevent spread of disease

18(1) In the event of an epidemic or a threatened epidemic, a medical officer of health may order any person, whether vaccinated, inoculated, or not, to be quarantined for a period of up to four weeks, and for a further period of up to four weeks if, in the opinion of the medical officer of health, the quarantine is required for the protection of the community.

18(2) In the event of an epidemic or threatened epidemic, a medical officer of health, or the director, may, with the consent of the minister, order the closing or quarantining, or both, of any school, church, or any other place or any other premises in the municipality or other area over which the medical officer of health or director has jurisdiction, for such period of time as the medical officer of health or director may deem necessary for the prevention, treatment, mitigation, and suppression of disease.

18(3) Where milk is suspected as the vehicle of the spread of a communicable disease, the medical officer of health may prohibit the sale or use of milk that has not been pasteurized or otherwise treated to his or her satisfaction.

18(4) Where water is suspected as the source of a communicable disease the medical officer of health may order that the water supply be not used unless it is chlorinated, boiled, or otherwise treated to his or her satisfaction.

18(5) Where food is suspected of being the cause of a communicable disease that food may be seized or disposed of to the satisfaction of the medical officer of health.

Duties of the medical officer of health

19(1) Every medical officer of health shall keep an accurate record in writing of

(a) every case of a notifiable disease reported to him or her by a duly qualified medical practitioner; and

(b) every other case of a notifiable disease

(i) otherwise reported to him or her, or

(ii) of which he or she has knowledge.

19(2) A medical officer of health shall send to the director by mail, within 24 hours after receipt thereof,

(a) every report of a case of a notifiable disease received by him or her from a duly qualified medical practitioner; and

en sont atteintes, qui font défaut de se soumettre à un examen requis aux termes d'un ordre délivré en application de la Loi ou des règlements, peuvent être mis en quarantaine dans leur propre domicile par le directeur ou le médecin hygiéniste en question pendant la période nécessaire pour permettre à ce dernier de s'assurer que ces personnes ne sont pas atteintes d'une maladie contagieuse.

Mesures pour prévenir la propagation de la maladie

18(1) En cas d'épidémie réelle ou appréhendée, un médecin hygiéniste peut ordonner la mise en quarantaine de toute personne, que celle-ci ait ou non été vaccinée ou inoculée, pendant une période d'au plus quatre semaines, et pendant une période supplémentaire maximale de quatre semaines, si, de l'avis du médecin hygiéniste, la mise en quarantaine est nécessaire pour la protection de la communauté.

18(2) En cas d'épidémie réelle ou appréhendée, un médecin hygiéniste, ou le directeur, peut, avec le consentement du ministre, ordoner la fermeture ou la mise en quarantaine, ou les deux, d'une école, d'une église ou d'un autre endroit, ou de locaux dans la municipalité ou région relevant de sa compétence, pendant la période qu'il estime nécessaire aux fins de la prévention, du traitement, de l'atténuation et de l'élimination de la maladie.

18(3) Dans les cas où l'on soupçonne que du lait est le vecteur de propagation d'une maladie contagieuse, le médecin hygiéniste peut interdire la vente ou l'utilisation de lait qui n'a pas été pasteurisé ou traité d'une manière qu'il juge satisfaisante.

18(4) Dans les cas où l'on soupçonne que l'eau est la source d'une maladie contagieuse, le médecin hygiéniste peut ordonner que l'eau ne soit pas utilisée avant d'avoir été chlorée, bouillie ou traitée d'une manière qu'il juge satisfaisante.

18(5) Dans les cas où l'on soupçonne que des aliments sont la cause d'une maladie contagieuse, les aliments en question peuvent être saisis ou éliminés d'une manière jugée satisfaisante par le médecin hygiéniste.

Obligations du médecin hygiéniste à l'égard des maladies à déclarer

19(1) Tout médecin hygiéniste tient un registre précis faisant état :

a) de tous les cas de maladie à déclarer qui lui ont été signalés par un médecin;

b) de tous les autres cas de maladie à déclarer :

(i) qui lui ont été signalés d'une autre manière,

(ii) dont il a connaissance.

19(2) Tout médecin hygiéniste transmet par la poste au directeur, dans les 24 heures de leur réception :

a) les rapports de cas de maladies à déclarer qu'il reçoit d'un médecin;

(b) full information respecting any other case of a notifiable disease of which he or she may be aware.

Isolation for notifiable disease

20(1) The director or the medical officer of health in ordering isolation in the case of a notifiable disease shall provide such detailed instructions as he or she considers advisable regarding isolation and the measures to be taken to protect other persons from contacting the disease.

20(2) Pending notification, a duly qualified medical practitioner attending a person suffering from a notifiable disease may take such action as he or she deems advisable to isolate or hospitalize that person, or to quarantine any contact or the premises occupied by that person or by any contacts; and the medical practitioner shall forthwith notify the medical officer of health of any action taken under this subsection.

20(3) The action taken by a duly qualified medical practitioner under subsection (2) continues in effect until varied or terminated by the director or by the medical officer of health.

Isolation

21 No person other than a duly qualified medical practitioner or a registered nurse shall enter or leave the area or room in which a person is isolated, unless that person has the permission of the medical officer of health.

22 All pets shall be removed and excluded from the room in which a person is isolated.

23(1) Where a person who has a notifiable disease, and who resides in premises directly connected with any store or place of business, is ordered isolated in the premises, the store or place of business may be quarantined.

23(2) Business in a store or place of business referred to in subsection (1) may be conducted as usual if

(a) the premises are so constructed that the part in which the person who has the notifiable disease is isolated can be, and is, effectively sealed off from the store or place of business to the satisfaction of the medical officer of health; and

(b) the employees and other persons connected with the store or other place of business during the period of isolation

(i) reside in premises other than the premises in which the person is isolated,

(ii) do not enter the area or room in which the person is isolated, and

(iii) do not come into contact with the person isolated or any article from the area or room in which the person is isolated.

b) tous les renseignements relatifs à quelque autre cas de maladie à déclarer dont il a connaissance.

Isolement en cas de maladie à déclarer

20(1) Le directeur ou le médecin hygiéniste qui ordonne l'isolement, dans un cas de maladie à déclarer, fournit les directives détaillées qu'il estime appropriées relativement à l'isolement et aux mesures à prendre pour éviter que d'autres personnes ne contractent la maladie.

20(2) Après avoir signalé un cas, le médecin qui soigne une personne atteinte d'une maladie à déclarer peut prendre les mesures qu'il estime appropriées aux fins de l'isolement ou de l'hospitalisation de cette personne, ou de la mise en quarantaine de tout contact ou des locaux occupés par cette personne ou par tout contact. Le médecin avise sans tarder le médecin hygiéniste des mesures qu'il prend en application du présent paragraphe.

20(3) Les mesures prises par un médecin en application du paragraphe (2) continuent de s'appliquer tant que le directeur ou le médecin hygiéniste ne les modifie pas ou n'y met pas fin.

Isolement

21 Exception faite des médecins ou des infirmières, seules les personnes autorisées à cette fin par le médecin hygiéniste peuvent entrer dans l'aire ou la pièce où une personne est isolée ou en sortir.

22 Les animaux domestiques doivent être retirés de la pièce où une personne est isolée.

23(1) Dans les cas où une personne atteinte d'une maladie à déclarer réside dans des locaux directement rattachés à un magasin ou à une place d'affaires et où on ordonne son isolement dans ces locaux, le magasin ou la place d'affaires en question peut être mis en quarantaine.

23(2) Il est permis d'exploiter normalement un magasin ou une place d'affaires mentionné au paragraphe (1) si les conditions suivantes sont réunies :

a) les locaux sont construits de telle sorte que la partie dans laquelle est isolée la personne atteinte de la maladie à déclarer peut être, et de fait est efficacement isolée du magasin ou de la place d'affaires, d'une manière jugée satisfaisante par le médecin hygiéniste;

b) pendant la période d'isolement, les employés et autres personnes en relation avec le magasin ou autre place d'affaires :

(i) résident dans des locaux autres que ceux dans lesquels la personne est isolée,

(ii) n'entrent pas dans l'aire ou la pièce où la personne est isolée,

(iii) ne viennent pas en contact avec la personne isolée ou avec tout article provenant de l'aire ou de la pièce où la personne est isolée.

24 With respect to each notifiable disease, the relevant rules, procedures, steps, and actions prescribed in Schedule B are recommended, and the director or the medical officer of health may order

(a) the patient;

(b) any person residing in the premises in which the patient is being treated or has resided; or

(c) any person attending the patient;

to follow, adopt, or carry out, any of those relevant recommended rules, procedures, steps, or actions and any person to whom such an order is given shall comply with the order.

Pets

25 The director may require a person receiving any pet from outside the province to notify the director of the time and place at which the pet was received and the place from which the pet was sent.

26 The medical officer of health may order the quarantine or isolation of any pet for the purpose of preventing the spread of a communicable disease, and the owner or the person to whom the pet or pets was sent shall bear the cost of the quarantine or isolation.

27(1) Where a medical officer of health finds that a bird is infected with psittacosis the medical officer of health may order the owner or any person in possession of it to have the bird adequately treated so as to render it non-infectious, or to have it destroyed.

27(2) Where the medical officer of health orders any pet to be quarantined, isolated, treated, or destroyed and the owner or any person in possession thereof fails to comply with the order, the medical officer of health may

(a) seize and take possession of the pet; and

(b) quarantine, isolate, treat, or destroy the pet or cause it to be destroyed;

and the cost of quarantine, isolation, treatment or destruction shall be paid by the owner or person in possession of the pet.

27(3) Where any pet has been quarantined or isolated by order of the medical officer of health, the quarantine or isolation shall not be terminated except by order of the medical officer of health.

28 Any order of quarantine or isolation of a pet made by a medical officer of health or the director shall not be varied or terminated except by the medical officer of health or the director.

29(1) In subsection (2), "turtle" means any reptile having a shell belonging to the class Chrlonia, and having a carapace length of less than six inches.

24 Sont recommandées, relativement à chaque maladie à déclarer les règles, procédures, étapes ou mesures pertinentes prescrites à l'annexe B. De plus, le directeur ou le médecin hygiéniste peut ordonner aux personnes énumérées ci-dessous de suivre, d'adopter ou de prendre l'une ou l'autre des règles, procédures, étapes ou mesures pertinentes recommandées et les personnes à qui un tel ordre est intimé sont tenues de s'y conformer. Les personnes visées au présent paragraphe sont les suivantes :

a) le patient;

b) toute personne résidant dans les locaux où une personne est traitée ou a résidé;

c) toute personne qui traite le patient.

Animaux domestiques

25 Le directeur peut exiger d'une personne ayant reçu un animal domestique provenant de l'extérieur de la province qu'elle l'avise du moment et de l'endroit où l'animal a été reçu ainsi que de l'endroit d'où il a été expédié.

26 Le médecin hygiéniste peut ordonner la mise en quarantaine ou l'isolement d'un animal domestique afin de prévoir la propagation d'une maladie contagieuse. Le propriétaire ou le destinataire de l'animal assume les coûts de la mise en quarantaine ou de l'isolement.

27(1) Lorsque le médecin hygiéniste découvre qu'un oiseau est infecté de la psittacose, il peut ordonner au propriétaire ou à la personne qui a l'oiseau en sa possession de le faire traiter de façon à le rendre non-infectieux ou de le faire éliminer.

27(2) Si le médecin hygiéniste ordonne la mise en quarantaine, l'isolement, le traitement ou l'élimination d'un animal domestique et que le propriétaire ou la personne qui a l'animal en sa possession fait défaut de se conformer à cet ordre, le médecin hygiéniste peut, aux frais du propriétaire ou de la personne qui a l'animal en sa possession :

a) saisir l'animal domestique et en prendre possession;

b) mettre l'animal domestique en quarantaine, l'isoler, le traiter ou encore l'éliminer ou le faire détruire.

27(3) Lorsqu'un animal domestique a été mis en quarantaine ou isolé sur ordre du médecin hygiéniste, la mise en quarantaine ou l'isolement ne prend fin que sur ordre à cet effet du médecin hygiéniste.

28 Les ordres de mise en quarantaine ou d'isolement donnés par un médecin hygiéniste ou par le directeur ne peuvent être modifiés ou déclarés terminés que par le médecin hygiéniste ou le directeur.

29(1) Pour l'application du paragraphe (2) le terme "tortue" s'entend de tout reptile à carapace, qui appartient à l'ordre des chéloniens et dont la carapace mesure moins de six pouces de longueur.

29(2) A copy of the notice set out in Form 6 of Schedule A shall be conspicuously displayed in any place where turtles, as defined in subsection (1) are offered for sale, distributed to, or handled, by the public.

30 The keeping of a skunk or skunks on any premises, other than a medical, or veterinarian research establishment or laboratory, a game farm or a zoological garden, is prohibited.

31(1) In the event of an animal bite to a person in which a physician determines that there is a possibility of transmission of rabies, the person bitten or any duly qualified medical practitioner or registered nurse attending that person shall forthwith notify the medical officer of health or the Animal Control Officer of the municipality in which the biting incident occurred or a Peace Officer of the details of the biting incident.

31(2) An Animal Control Officer or Peace Officer receiving a report pursuant to subsection (1) shall notify the medical officer of health of the details of the report at the earliest possible opportunity.

PART II
SEXUALLY TRANSMITTED DISEASE

Definitions
32 In this Part,

"physician" means a duly qualified medical practitioner; ("médecin")

"sexually transmitted disease" means a venereal disease specified in section 6 ("maladie transmise sexuellement")

Diagnosis of gonorrhea
33 For the purposes of this Part, a diagnosis of gonorrhea shall be made on the basis of

(a) a review of the medical history and a physical examination of the person; and
(b) either,
(i) the identification of Gram-negative intracellular diplococci from the urethra, or
(ii) the identification of Neisseria gonorrhoeae in a specimen taken from any anatomical site.

Diagnosis of syphilis
34 For the purpose of this Part, a diagnosis of syphilis shall be made on the basis of

(a) a review of the medical history and a physical examination of the person;
(b) a serological test for syphilis carried out at a laboratory designated by the director; and
(c) where there is a chancre or other infectious lesion the laboratory test shall include the darkfield microscopical examination or another examination acceptable to the director for Treponema pallidum.

29(2) Une copie de l'avis prévu à la formule 6 de l'annexe A doit être affichée à un endroit bien en vue dans tout lieu où des tortues, au sens du paragraphe (1), sont offertes en vente ou distribuées au public, ou manipulées par lui.

30 Il est interdit de garder des mouffettes dans des locaux autres qu'un établissement ou un laboratoire de recherche médicale ou vétérinaire, une ferme d'élevage de gibier ou un jardin zoologique.

31(1) Lorsqu'un animal mord une personne et qu'un médecin détermine qu'il y a possibilité de transmission de la rage, la personne mordue ou encore le médecin ou l'infirmière qui traite cette personne donne sans tarder au médecin hygiéniste ou au responsable de la fourrière de la municipalité où l'incident est survenu, ou encore à un agent de la paix un avis faisant état du détail de l'incident.

31(2) Le responsable de la fourrière ou l'agent de la paix qui reçoit un rapport en application du paragraphe (1) communique le plus rapidement possible au médecin hygiéniste le détail de ce rapport.

PARTIE II
MALADIE TRANSMISE SEXUELLEMENT

Définitions
32 Les définitions qui suivent s'appliquent à la présente partie.

"maladie transmise sexuellement" Maladie vénérienne visée à l'article 6. ("sexually transmitted disease")

"médecin" Médecin dûment qualifié à exercer la médecine. ("physician")

Diagnostic de la gonorrhée
33 Pour l'application de la présente partie, un diagnostic de gonorrhée est établi lorsque les conditions qui suivent sont remplies :

a) étude des antécédents médicaux et examen physique de la personne;
b) selon le cas :
(i) détection du diplocoque encapsulé, Gram négatif, dans l'urètre,
(ii) détection du Neisseria gonorrhoeae dans un échantillon prélevé dans un site anatomique.

Diagnostic de la syphilis
34 Pour l'application de la présente partie, un diagnostic de syphilis est établi lorsque les conditions qui suivent sont remplies :

a) étude des antécédents médicaux et examen physique de la personne;
b) examen sérologique de la syphilis pratiqué dans un laboratoire désigné par le directeur;
c) si la personne a un chancre ou une autre lésion infectieuse, l'épreuve de laboratoire comprend un examen à l'ultramicroscope ou un autre examen que le directeur juge acceptable pour détecter le tréponème pâle.

Diagnosis of chancroid

35 For the purposes of this Part, a diagnosis of chancroid shall be made on the basis of

(a) a review of the medical history and a physical examination of the person; and

(b) the laboratory identification of Haemophilus ducreyi in a specimen taken from any anatomical site.

Diagnosis of chlamydia

36 For the purposes of this Part, a diagnosis of chlamydia shall be made on the basis of

(a) a review of the medical history and a physical examination of the person; and

(b) the laboratory identification of Chlamydia trachomatis in a specimen taken from an appropriate anatomical site.

Diagnosis of AIDS

37 For the purposes of this Part, a diagnosis of AIDS shall be made on the basis of

(a) a physical examination and the medical history of the person;

(b) a positive laboratory test for

(i) human immunodeficiency virus (HIV), or

(ii) the serum antibody to human immunodeficiency virus (HIV);

(c) the occurence of Pneumocystis carinii pneumonia, Kaposi's sarcoma or another opportunistic disease that is at least moderately indicative of cellular immunodeficiency in the absence of

(i) all known causes of cellular immunodeficiency, and

(ii) all other causes of reduced resistance reported to be associated with any such opportunistic disease; and

(d) any additional medical criteria which the director considers appropriate.

Gonorrhea considered infectious

38 For the purposes of this Part, a person with gonorrhea is considered infectious until

(a) prescribed treatment has been completed; and

(b) either,

(i) at least one laboratory examination satisfactory to the director, taken after completion of treatment, fails to show Neisseria gonorrhoeae, or

(ii) the director is satisfied that the danger of communication of such infection to other persons no longer exists.

Syphilis considered infectious

39 For the purposes of this Part, a person with syphilis is considered infectious until

(a) prescribed treatment has been completed; and

(b) either,

(i) all lesions of the skin or mucous membranes are completely healed, or

Diagnostic du chancre

35 Pour l'application de la présente partie, un diagnostic de chancre est établi lorsque les conditions qui suivent sont remplies :

a) étude des antécédents médicaux et examen physique de la personne;

b) détection en laboratoire du Haemophilus ducreyi dans un échantillon prélevé dans un site anatomique.

Diagnostic du chlamydia

36 Pour l'application de la présente partie, un diagnostic de chlamydia est établi lorsque les conditions qui suivent sont remplies :

a) étude des antécédents médicaux et examen physique de la personne;

b) détection en laboratoire du Chlamydia trachomatis dans un échantillon prélevé dans un site anatomique approprié.

Diagnostic du SIDA

37 Pour l'application de la présente partie, un diagnostic de SIDA est établi lorsque les conditions qui suivent sont remplies :

a) étude des antécédents médicaux et examen physique de la personne;

b) résultat positif :

(i) soit d'une épreuve de laboratoire pou détecter le virus de l'immunodéficience humaine (VIH),

(ii) soit d'une épreuve sérologique pour détecter l'anticorps anti-virus de l'immunodéficience humaine (VIH),

c) présence de pneumonie à Pneumocystis carinii, du sarcome de Kaposi ou de toute autre maladie opportuniste qui constitue un indice suffisamment concluant d'immunodéficience cellulaire en l'absence :

(i) de toute cause connue d'immunodéficience cellulaire,

(ii) de toute autre cause de résistance affaiblie qu'entraîne normalement une telle maladie opportuniste,

d) tout autre critère médical que le directeur juge pertinent.

Gonorrhée contagieuse

38 Pour l'application de la présente partie, une personne atteinte de la gonorrhée est considérée contagieuse tant que les conditions qui suivent n'ont pas été remplies :

a) le traitement prescrit est terminé;

b) selon le cas,

(i) au moins une épreuve de laboratoire que le directeur juge satisfaisante ne révèle pas la présence du Neisseria gonorrhoeae après la fin du traitement,

(ii) le directeur juge qu'il n'y a plus aucun risque de contagion.

Syphilis contagieuse

39 Pour l'application de la présente partie, une personne atteinte de la syphilis est considérée contagieuse tant que les conditions qui suivent n'ont pas été remplies :

a) le traitement prescrit est terminé;

b) selon le cas,

(i) les lésions de la peau ou des muqueuses sont complètement guéries,

(ii) the director is satisfied that the danger of communication of such infection to other persons no longer exists.

Chancroid considered infectious

40 For the purposes of this Part, a person with chancroid is considered infectious until

(a) prescribed treatment has been completed;

(b) all lesions of the skin or mucous membranes are completely healed; and

(c) either,

(i) at least one laboratory examination taken after completion of treatment and satisfactory to the director, fails to show Haemophilus ducreyi, or

(ii) the director is satisfied that the danger of communication of such infection to other persons no longer exists.

Chlamydia considered infectious

41 For the purposes of this Part, a person with chlamydia is considered infectious until

(a) prescribed treatment has been completed; and

(b) either,

(i) at least one laboratory examination taken after completion of treatment and satisfactory to the director, fails to show Chlamydia trachomatis, or

(ii) the director is satisfied that the danger of communication of such infection to other persons no longer exists.

AIDS considered infectious

42 For the purposes of this Part, a person with acquired immune deficiency syndrome (AIDS) is considered infectious until the director is satisfied that the danger of communication of such infection to other persons no longer exists.

Physician's duty to report disease

43(1) A physician who, while attending a person, forms the opinion that the person has or may have a sexually transmitted disease shall

(a) as soon as possible after forming the opinion, make a report to the director; and

(b) where that person has been in contact with another person in circumstances from which it reasonably can be expected that the infected person has transmitted the disease to another person, or has been infected by another person, report the contact to the director.

43(2) The report shall be in Form 7 of Schedule A and shall include full information, including details of the methods of examination carried out.

Physician to report refusal or neglect of treatment

44(1) A physician who, having attended on a person and having diagnosed the person as having gonorrhea, syphilis, chancroid or chlamydia in an infectious form, shall make a report to the director where

(a) the person fails to consult the physician within a period of seven days from the previous consultation; and

(b) the physician has reason to believe that the person may have the disease in an infectious form.

(ii) le directeur juge qu'il n'y a plus aucun risque de contagion.

Chancre contagieux

40 Pour l'application de la présente partie, une personne atteinte du chancre est considérée contagieuse tant que les conditions qui suivent n'ont pas été remplies :

a) le traitement prescrit est terminé;

b) les lésions de la peau ou des muqueuses sont complètement guéries,

c) selon le cas,

(i) au moins une épreuve de laboratoire que le directeur juge satisfaisante ne révèle pas la présence du Haemophilus ducreyi après la fin du traitement,

(ii) le directeur juge qu'il n'y a plus aucun risque de contagion.

Chlamydia contagieux

41 Pour l'application de la présente partie, une personne atteinte du chlamydia est considérée contagieuse tant que les conditions qui suivent n'ont pas été remplies :

a) le traitement prescrit est terminé;

b) selon le cas,

(i) au moins une épreuve de laboratoire que le directeur juge satisfaisante ne révèle pas la présence du Chlamydia trachomatis après la fin du traitement,

(ii) le directeur juge qu'il n'y a plus aucun risque de contagion.

SIDA contagieux

42 Pour l'application de la présente partie, une personne atteinte du syndrome d'immunodéficience acquise est considérée contagieuse tant que le directeur juge qu'il y a un risque de contagion.

Obligation du médecin de déclarer la maladie

43(1) Un médecin qui, en soignant une personne, conclut que celle-ci a ou pourrait avoir une maladie transmise sexuellement est tenu de prendre les mesures suivantes :

a) remettre un rapport au directeur le plus tôt possible après être arrivé à cette conclusion;

b) communiquer au directeur le nom des partenaires de la personne qui auraient vraisemblablement contracté la maladie ou qui la lui aurait transmise.

43(2) Le rapport, rédigé selon le modèle de la formule 7 figurant à l'annexe A de la présente partie, est rempli de façon détaillée et décrit les méthodes d'examen employées.

Obligation du médecin de signaler le nom de toute personne qui refuse ou néglige de suivre le traitement

44(1) Un médecin qui soigne une personne et qui établit un diagnostic de gonorrhée, de syphilis, de chancre ou de chlamydia contagieux remet un rapport au directeur dans les cas suivants :

a) la personne ne voit pas le médecin dans les sept jours de la consultation précédente;

b) le directeur croit que la personne est contagieuse.

44(2) The physician making a report under subsection (1) shall provide such information as the director requests.

Physician to secure specimens

45 Where a physician has diagnosed a person as having a sexually transmitted disease or has formed the opinion that a person may have a sexually transmitted disease, the physician shall,

(a) wherever possible, secure specimens for examination and forward them for examination to a laboratory approved by the director; or

(b) if requested by the director, secure specimens for examination and forward them to a laboratory specified by the director.

Labelling of specimens

46 A physician shall label each specimen submitted to a laboratory

(a) for examination for the detection of syphilis, gonorrhea, chancroid or chlamydia with the name, sex, date of birth, address and the Manitoba Health Services Commission registration number of the person from whom the specimen was secured, the specimen site and the date taken; and

(b) for examination for the detection of the Human immunodeficiency virus (HIV), as follows:

(i) in a manner which shall preserve confidentiality,

(ii) with the sex and the day and year of birth of the person from whom it was secured, and

(iii) with the date the specimen was taken.

Report by laboratory operator

47 The person in charge of a laboratory shall, within 48 hours of the time that each result is known, report to the director

(a) all positive results of tests for Neisseria gonorrhoeae;

(b) all positive results of tests for Treponema pallidum;

(c) all positive results of tests for Haemophilus ducreyi;

(d) all positive results of tests for Chlamydia trachomatis; and

(e) all positive results of

(i) a serologic test for the presence of antibody to the Human immunodeficiency virus (HIV), or

(ii) the laboratory identification of the Human immunodeficiency virus (HIV).

Medical order by director

48 Where the director, upon reasonable and probable grounds, believes

(a) that a person has or may have a sexually transmitted disease; or

(b) that a person has been in contact with another person who has a sexually transmitted disease under circumstances from which it reasonably can be expected that the first named person may have been exposed to a sexually transmitted disease;

the director may make an order in Form 8 of Schedule A requiring the person to take any one or more of the actions set out in the order.

44(2) Le médecin qui fait un rapport aux termes du paragraphe (1) fournit au directeur les renseignements que celui-ci lui demande.

Prélèvement d'échantillons

45 Le médecin qui établit un diagnostic de maladie transmise sexuellement ou qui croit qu'une personne pourrait avoir une telle maladie prend les mesures suivantes :

a) autant que possible, il prélève des échantillons et les fait parvenir à un laboratoire approuvé par le directeur pour qu'ils y soient examinés;

b) à la demande du directeur, il prélève des échantillons et les fait parvenir à un laboratoire approuvé par le directeur pour qu'ils y soient examinés.

Étiquetage des échantillons

46 Le médecin étiquète les échantillons remis à un laboratoire :

a) aux fins de détection de la syphilis, de la gonorrhée, du chancre ou du chlamydia, en indiquant le nom, le sexe, la date de naissance, l'adresse et le numéro d'inscription à la Commission des services de santé du Manitoba du malade, ainsi que le site et la date de prélèvement;

b) aux fins de détection du virus de l'immunodéficience humaine (VIH) :

(i) d'une manière qui assurera la confidentialité,

(ii) en indiquant le sexe, le jour et l'année de naissance du malade,

(iii) en indiquant la date de prélèvement.

Rapport du responsable du laboratoire

47 Dans les 48 heures suivant l'obtention des résultats, le responsable du laboratoire fait part au directeur :

a) des résultats positifs des épreuves pour détecter le Neisseria gonorrhoeae;

b) des résultats positifs des épreuves pour détecter le tréponème pâle;

c) des résultats positifs des épreuves pour détecter le Haemophilus ducreyi;

d) des résultats positifs des épreuves pour détecter le Chlamydia trachomatis;

e) des résultats positifs :

(i) soit des examens sérologiques pour détecter l'anticorps anti-virus de l'immunodéficience humaine (VIH),

(ii) soit des épreuves de laboratoire pour détecter le virus de l'immunodéficience humaine (VIH).

Ordre d'examen médical

48 Le directeur peut donner un ordre, selon le modèle de la formule 8 figurant à l'annexe A, contraignant une personne à prendre une ou plusieurs des mesures qui y sont énoncées s'il a des raisons valables de croire :

a) soit que cette personne a ou pourrait avoir une maladie transmise sexuellement;

b) soit que cette personne a eu des relations avec un partenaire atteint d'une maladie transmise sexuellement qui la lui aurait vraisemblablement communiquée.

Supply of drugs etc. by unqualified person prohibited
49 No person other than
(a) a physician;
(b) a registered nurse acting under the supervision of a physician; or
(c) a licensed pharmacist who dispenses a drug, medicine or appliance to a person upon a written prescription signed by a physician;
shall attend upon, prescribe, supply, or offer to supply any drug, medicine or appliance, to or for another person for the purpose of diagnosing, alleviating or curing a sexually transmitted disease.

Documents prohibited
50 No person shall issue, give, use, or display any document or other form of writing that represents that any person is free from a sexually transmitted disease.

Confidentiality
51 Except where otherwise required by law, no person engaged in the administration of this Part shall disclose any matter which may come to that person's knowledge in the course of that person's duties, except
(a) to other persons engaged in the performance of duties under this Part to the extent necessary to fulfill such duties; or
(b) upon the written instruction of the minister.

PART III
DEAD BODIES

Definitions
52 In this Part, "communicable disease" or "contagious disease" means cholera, diphtheria, typhoid fever, louse-borne typhus fever, plague, anthrax, tularemia, brucellosis, yellow fever, and louse-borne relapsing fever.

Interment
53 Burial of a dead body shall be made in such a manner as to allow the outer container for the body to be completely covered by earth to a depth of at least three feet as measured up to the level of the surrounding ground.

Mourning draperies etc.
54 No person shall introduce draperies or other mourning ornaments or decorations into any house infected with a contagious disease unless the articles, before removal, are destroyed or disinfected to the satisfaction of the medical officer of health.

Death by contagious disease
55(1) The body of any person who has died of contagious disease
(a) shall be thoroughly washed with an effective disinfectant solution satisfactory to the medical officer of health;

Personnes autorisées à fournir des médicaments
49 Seuls les professionnels de la santé mentionnés ci-dessous sont autorisés à donner des soins à une personne pour diagnostiquer, soulager ou guérir une maladie transmise sexuellement ou à prescrire, à fournir ou à offrir de fournir des médicaments, des remèdes ou des appareils à cette personne ou pour une autre :
a) un médecin;
b) une infirmière sous la supervision d'un médecin;
c) un pharmacien qui délivre des médicaments, des remèdes ou des appareils sur présentation d'une ordonnance signée par un médecin.

Documents interdits
50 Il est interdit de publier, de donner, d'utiliser et d'afficher des documents ou des écrits indiquant qu'une personne n'a pas une maladie transmise sexuellement.

Confidentialité
51 Sauf indication contraire de la loi, il est interdit à quiconque chargé de l'administration du Contrôle des maladies contagieuses de dévoiler des renseignements obtenus dans le cadre de l'exercice de ses fonctions, sauf dans l'un ou l'autre des cas suivants :
a) la divulgation des renseignements est nécessaire pour permettre à d'autres membres du personnel du Contrôle des maladies contagieuses d'exercer leurs fonctions;
b) le ministre autorise par écrit la divulgation de renseignements.

PARTIE III
CADAVRES

Définitions
52 Pour l'application de la présente partie, l'expression "maladie contagieuse" s'entend du choléra, de la diphtérie, de la fièvre typhoïde, du typhus exanthématique, de la variole, de la peste, du charbon, de la tularémie, de la brucellose, de la fièvre jaune et de la fièvre récurrente transmise par le pou.

Inhumation
53 L'enterrement doit être effectué de façon que le cercueil ou le contenant renfermant celui-ci soit entièrement recouvert de terre, à une profondeur d'au moins trois pieds sous la surface du sol environnant.

Tentures funèbres
54 Il est interdit d'apporter des tentures ou autres ornements ou décorations funèbres dans une maison infectée par une maladie contagieuse sauf si ces articles sont détruits ou désinfectés, d'une manière jugée satisfaisante par le médecin hygiéniste avant d'être enlevés de cet endroit.

Décès attribuable à une maladie contagieuse
55(1) Les dispositions suivantes doivent être respectées à l'égard du corps d'une personne décédée d'une maladie contagieuse :
a) le corps doit être lavé entièrement à l'aide d'un désinfectant efficace jugé satisfaisant par le médecin hygiéniste;

(b) shall have the orifices blocked with absorbent cotton;
(c) shall, at the earliest possible time after death, be placed in a coffin, tightly constructed, which shall be permanently closed to prevent its being re-opened and to prevent leakage;
(d) shall be buried within 48 hours after death, unless the body has been embalmed or a special permit postponing burial has been obtained from the medical officer of health;
(e) shall not be taken out of the neighbourhood in which death occurred, without the written permit of the medical officer of health having authority in the area in which death occurred; and
(f) shall not be accompanied by contaminated articles.

55(2) A coffin closed and fastened in accordance with clause (1)(c) may be re-opened for purposes of
(a) inspection for identification;
(b) a post mortem examination; or
(c) cremation.

Disinterment
56(1) No person shall open a coffin containing a body of a person who has died of a communicable disease without the authorization in writing of the medical officer of health.

56(2) No person shall disinter a dead body except as provided in sections 29 to 33 of the Act.

Transportation of dead bodies
57 Except where necessary immediately following death, the body of a person who has died of a contagious disease shall not be transported by railway, boat, air transport, or other public conveyance, unless
(a) prepared in accordance with section 55;
(b) the coffin in which it is contained is
(i) constructed of, or lined with, metal or other impervious materials and hermetically sealed, or
(ii) placed in a tightly constructed outer container constructed of, or lined with, metal or other impervious material and hermetically sealed;
(c) the necessary registration of death has been made; and
(d) there is securely attached at the head end of the outside of the coffin or outer container, as the case may be, a transit certificate in Form 9 of Schedule A, properly completed and signed by a funeral director or embalmer licensed to do business in Manitoba.

b) les orifices du corps doivent être obturés à l'aide de coton absorbant;
c) aussitôt que possible après le décès, le corps doit être placé dans un cercueil de construction serrée, qui doit être fermé de façon permanente afin d'empêcher toute réouverture ou fuite;
d) le corps doit être inhumé dans les 48 heures qui suivent le décès, sauf s'il a été embaumé ou si un permis spécial a été délivré par le médecin hygiéniste afin de retarder l'inhumation;
e) le corps ne peut être transporté à l'extérieur du voisinage où le décès est survenu sans un permis écrit à cette fin délivré par le médecin hygiéniste qui a compétence dans la région où le décès est survenu;
f) le corps ne peut être accompagné d'objets contaminés.

55(2) Une fois fermé et verrouillé conformément à l'alinéa (1)c), un cercueil peut être rouvert pour les fins suivantes :
a) inspection à des fins d'identification;
b) examen post mortem;
c) crémation.

Exhumation
56(1) Nul ne peut ouvrir un cercueil renfermant le corps d'une personne décédée d'une maladie contagieuse sans l'autorisation écrite du médecin hygiéniste.

56(2) L'exhumation d'un cadavre doit se faire conformément aux dispositions des articles 29 à 33 de la Loi.

Transport des cadavres
57 Sauf dans les cas où cela est nécessaire immédiatement après le décès, le corps d'une personne décédée d'une maladie contagieuse ne peut être transporté par train, par bateau, par transport aérien, ou par un autre moyen de transport public que si les dispositions suivantes sont respectées :
a) le corps a été préparé conformément à l'article 55;
b) le cercueil dans lequel repose le corps est :
(i) soit fait ou recouvert de métal ou d'un autre matériau imperméable, et scellé hermétiquement,
(ii) soit placé dans un contenant de construction serrée, lui-même fait ou recouvert de métal ou d'un autre matériau imperméable, et scellé hermétiquement;
c) les formalités d'enregistrement du décès nécessaires ont été effectuées;
d) un certificat de transit préparé selon la formule 9 de l'annexe A, dûment rempli et signé par un entrepreneur de pompes funèbres ou un embaumeur titulaire d'un permis l'autorisant à faire affaire au Manitoba est solidement attaché à l'extrémité supérieure de l'extérieur du cercueil ou du contenant dans lequel se trouve celui-ci.

58(1) The body of a person who has died of a disease other than a contagious disease may be received for transportation and may be transported, when enclosed in a sound coffin, if it will reach its destination within 72 hours from the time of death.

58(2) Where transportation cannot be completed within 72 hours, a body shall not be accepted for transportation unless it has been embalmed by a licensed embalmer or is enclosed in :

(a) a coffin constructed of, or lined with, metal or other impervious material and hermetically sealed; or

(b) a coffin placed in a tightly constructed outer container constructed of, or lined with, metal or other impervious material and hermetically sealed.

58(3) No person shall transport, or cause to be transported, to another country the body of a person who has died unless

(a) the body is thoroughly washed with an effective disinfectant, and all orifices are disinfected and packed with cotton saturated with an effective disinfectant, and the body is wrapped in a sheet saturated with an effective disinfectant, and it is placed in an impervious coffin;

(b) the body is properly embalmed and placed in an impervious coffin; or

(c) the body is properly embalmed and encased in a plastic container which has been sealed by heat or by adhesive materials prior to placement in a non-impervious coffin;

and a transit certificate in the form prescribed in Form 9 of Schedule A, properly completed and signed by a funeral director or embalmer licensed to do business in Manitoba, is presented, and a copy of the transit certificate is securely attached at the head end of the outside of the coffin or outer container, as the case may be.

58(4) Where the body is cremated, the transportation of the ashes is not subject to this regulation.

58(1) Le corps d'une personne décédée d'une maladie autre qu'une maladie contagieuse peut être accepté pour fins de transport et être transporté, dans un cercueil solide, à la condition d'arriver à destination dans les 72 heures qui suivent le moment du décès.

58(2) Si le transport ne peut être complété dans les 72 heures, le corps ne peut être transporté que s'il a été embaumé par un embaumeur titulaire d'un permis ou s'il repose :

a) soit dans un cercueil fait ou recouvert de métal ou d'un autre matériau imperméable, et scellé hermétiquement;

b) soit dans un cercueil placé dans un contenant de construction serrée, lui-même fait ou recouvert de métal ou d'un autre matériau imperméable, et scellé hermétiquement.

58(3) Nul ne peut transporter ou permettre que soit transporté dans un autre pays le corps d'une personne décédée à moins de préparer le corps de l'une ou l'autre des façons suivantes :

a) le corps doit être entièrement lavé à l'aide d'un désinfectant efficace, les orifices du corps doivent être désinfectés et obturés à l'aide de coton saturé d'un désinfectant efficace, le corps doit finalement être enveloppé dans un drap saturé d'un désinfectant efficace et placé dans un cercueil étanche;

b) le corps doit être embaumé de façon appropriée et placé dans un cercueil étanche;

c) le corps doit être embaumé de façon appropriée et placé dans un contenant en plastique qui a été scellé à l'aide de la chaleur ou de matériaux adhésifs avant d'être placé dans un cercueil non étanche;

De plus, un certificat de transit préparé au moyen de la formule 9 de l'annexe A, dûment rempli et signé par un entrepreneur de pompes funèbres ou un embaumeur titulaire d'un permis l'autorisant à faire affaire au Manitoba doit être présenté, et une copie de ce certificat de transit doit être solidement attachée à l'extrémité supérieure de l'extérieur du cercueil ou du contenant dans lequel se trouve celui-ci, selon le cas.

58(4) Dans le cas des corps incinérés, le transport des cendres n'est pas assujetti au présent règlement.

SCHEDULES

Schedule A - Forms

Form 1	Report of Communicable Diseases
Form 2	Epidemiological Report
Form 3	Report of Malignant Neoplasm
Form 4	Notification of Death
Form 5	Monthly Report of Communicable Diseases
Form 6	Caution re: Turtles
Form 7	Notification of Sexually Transmitted Disease
Form 8	Order for a Medical Examination of a Person by a Physician
Form 9	Certificate of Embalmer or Funeral Director

Schedule B Procedures for Notifiable Diseases

ANNEXES

Annexe A - Formules

Formule 1	Rapport sur les maladies contagieuses
Formule 2	Rapport épidémiologique
Formule 3	Rapport sur le néoplasme malin
Formule 4	Avis de décès
Formule 5	Rapport mensuel sur les maladies contagieuses
Formule 6	Danger causé par les tortues
Formule 7	Avis de maladie transmise sexuellement
Formule 8	Ordre d'examen médical d'une personne par un médecin
Formule 9	Certificat d'embaumeur ou d'entrepreneur de pompes funèbres

Annexe B Procédure concernant les maladies à déclaration obligatoire

SCHEDULE A
Forms

Form 1
(Section 3)

REPORT OF COMMUNICABLE DISEASES
REGULATIONS UNDER THE PUBLIC HEALTH ACT
To be filled out by the Attending Physician or Hospital

PLEASE PRINT - PRESS HARD

ONSET DATE_____

Postal Code

City
Municipality
Town or Village_____

Name_____

Address_____
City, St. & No (Sec. Tp., Rge) Hosp or Camp

Racial Origin_____(Treaty Indian)
(If Treaty Indian underline)

Sex_____Age_____

Was patient immunized against this disease? Yes No

Material Used_____Doses_____Year_____

Is Diagnosis Clinical?_____Laboratory?_____

ATTENDING PHYSICIAN_____
Please print

SIGNATURE_____

AS A CASE OF (Underline)

Intestinal Infectious Diseases

*Typhoid fever
Paratyphoid fever
Salmonella infections
Shigellosis
*Food poisoning (bacterial)
Staphylococcal
Botulism
C. perfringens
B. cereus
Other (specify below)
E. coli enteritis

Other Bacterial Diseases

Brucellosis
*Diphtheria cases
Diphtheria carriers
*Meningococcal infections
Pertussis
Sexually transmitted Diseases - Use STD Form
Tuberculosis - specify type below

Diseases of Central Nervous System

Meningitis
A. Bacterial
Haemophilus
Pneumococcal
Other (specify below)
B. Viral
Aseptic meningitis due to Coxsackie
Echo virus
Other viral (specify below) or unknown
Encephalitis
Western Equine Encephalitis
Other Viral Encephalitis (specify)
Other Viral Diseases
Hepatitis A
Hepatitis B
Measles
Mumps
Rubella
Congenital Rubella

OTHER DISEASES INCLUDING RARE* AND IMPORTED* (SPECIFY)

_____

ADDITIONAL INFORMATION_____

Fill out separate card for each case. For epidemics of other diseases use surveillance report.
Telephone report to Medical Officer of Health or Communicable Disease Control (945-6834 or 1-800-782-8402)for diseases indicated by (*).
This copy for MEDICAL OFFICER OF HEALTH

ANNEXE A
FORMULES

Formule 1
(Article 3)

RAPPORT CONCERNANT DES MALADIES À DÉCLARER
RÈGLEMENTS PRIS EN APPLICATION DE LA LOI SUR LA SANTÉ PUBLIQUE
Doit être rempli par le médecin traitant ou l'hôpital

ÉCRIRE EN CARACTÈRES D'IMPRIMERIE – APPUYER FORTEMENT

DATE DU DÉBUT _____

Code postal

Cité
Municipalité
ville ou village _____

Nom _____

Adresse _____
rue et n° civique (sec., tp., rg) hôp. ou camp

Race d'origine _____ (Indien visé par un traité)
(S'il s'agit d'un Indien visé par un traité, souligner)

Sexe _____ Âge _____

Le patient était-il immunisé contre la maladie? Oui Non

Substance utilisée _____ Doses _____ Année _____

Diagnostic clinique?_____ Laboratoire? _____

MÉDECIN TRAITANT _____
(en caractères d'imprimerie)

SIGNATURE_____

CAS DE (Souligner)

Maladies infectieuses intestinales

*Fièvre typhoide
Fièvre paratyphoide
Infections à salmonellose
Shigellose
*Toxi-infection alimentaire (bactérienne)
à staphylocoques
botulisme
à C. perfringens
à B. Cereus
Autres (préciser ci-dessous)
Enterite à E. coli

Autres maladies bactériennes

Brucellose
*Cas de diphtérie
Porteurs de diphtérie
*Infections à méningocoques
Coqueluche
Tuberculose (préciser le genre ci-dessous)
Maladies à transmission sexuelle (utiliser la formule MTS)

Maladies du système nerveux central

Méningite
A. Bactérienne
à Haemophilus
à pneumocoques
Autres (préciser ci-dessous)
B. Virale
Méningite aseptique due au virus de Coxsachie
Virus ECHO
Autres méningites virales (préciser ci-dessous
Encéphalite
Encéphalite équine occidentale
Autres encéphalite virales (préciser)
Autres maladies virales
Hépatite A
Hépatite B
Oreillons
Rougeole
Rubéole
Rubéole congénitale

AUTRES MALADIES, Y COMPRIS LES MALADIES RARES* ET IMPORTÉES* (PRÉCISER)

RENSEIGNEMENTS ADDITIONNELS_____

Remplir une carte distincte pour chaque cas. Pour les épidémies d'autres maladies, utiliser le rapport de surveillance.
Signaler la maladie par téléphone au médecin hygiéniste ou au Contrôle des maladies contagieuses (945-6834 ou 1-800-782-8402) s'il s'agit d'une maladie précédée d'un (*).

Copie du MÉDECIN HYGIÉNISTE

FORM 2
(Section 4)

EPIDEMIOLOGICAL REPORT

(Use for epidemics or disease episodes of Public Health significance)

DISEASE: First Report:

Location of Outbreak Progress Report:

Date of Onset of First Case: Date:

EPIDEMIOLOGICAL FEATURES (number of cases, number of deaths, population at risk, age, sex, race, mode of spread etc.)

LABORATORY RESULTS (if available):

ACTION TAKEN OR PLANNED - ADDITIONAL MEASURES LIKELY TO BE REQUIRED:

REPORTED BY: (please print)

Name: _____

Title: _____

Health Unit: _____

Address: _____

Date: _____

COMMENTS BY DIRECTOR

Signature: _____

Date: _____

FOR PUBLICATION [ ] NOT FOR PUBLICATION [ ]

Distribution: two copies to Director, Communicable Disease Control.

Formule 2
(Article 4)

RAPPORT ÉPIDÉMIOLOGIQUE

(Utiliser en cas d'épidémies ou d'épisodes de maladies d'importance en matière de santé publique)

MALADIE : ;

Premier rapport :

Endroit de la première manifestation :

Rapport périodique :

Date du début du premier cas :

Date :

PARTICULARITÉS ÉPIDÉMIOLOGIQUES (nombre de cas, nombre de décès, population à risque, âge, sexe, race, mode de propagation, etc.)

RÉSULTATS DE LABORATOIRE (si disponibles) :

MESURES PRISES OU PRÉVUES – MESURES ADDITIONNELLES SUSCEPTIBLES D'ÊTRE NÉCESSAIRES :

AUTEUR DU RAPPORT PAR : (en caractères d'imprimerie)

Nom : _____

Titre : _____

Unité de santé : _____

Adresse : _____

Date : _____

COMMENTAIRES DU DIRECTEUR :

Signature : _____

Date : _____

DESTINÉ À LA PUBLICATION [ ]

NON DESTINÉ À LA PUBLICATION [ ]

Distribution : deux copies au directeur du Contrôle des maladies contagieuses.

FORM 3
(Section 7)

The Province of Manitoba

REPORT OF MALIGNANT NEOPLASM under The Public Health Act

Physician Reporting

Today's Date
Year| Month| Day

Address

PATIENT IDENTIFICATION

Last Name

Mr. [ ] Mrs. [ ] Miss [ ]

First Name

Initials

Maiden Surname (if Applicable)

Husband's Initials

Apt. No. Street No. Street

City

Province

Marital Status:
Single [ ] Married [ ] Widowed [ ] Separated [ ]
Divorced [ ]

Date Of Birth
Year| Month| Day

MHSC No.

CURRENT CANCER DIAGNOSIS

Cancer Diagnosis

Primary Site

Histology

Method(s) Of Diagnosis

Pathological [ ] Clinical [ ]

Cytological [ ] Autopsy Only [ ]

Radiological [ ] Or Scan Mammography [ ]

Other

Stage

T(Tumor)

N(Node)

M (Metastasis)

Date First Diag.
Year| Month| Day

TREATMENT

Type of First Treatment

Given On
Year| Month| Day

At (Hospital, Name, Office, Etc.)

Subsequent Treatment

Year | Month | Day

At

Patient Referred To

Other Previous Cancer?

If Yes, Please Give Date

PATIENT STATUS CURRENT

Dr. to Contact For Yearly Follow-up is:

Dr.
Name

Address

Patient Last Seen
Year| Month| Day

Cancer Status At That Time

If Patient Deceased:

Date Of Death
Year|Month| Day

Place of Death

Cause of Death

Autopsy Done
Yes [ ] No [ ]

Year | Month | Day

And Primary Site

COMMENTS

Signature of Physician

This Form Should be Completed Once at the First Cancer Diagnosis and Again for Each New Primary Cancer.

Forward To: Central Cancer Registry
Manitoba Cancer Foundation
700 Bannatyne Avenue, Winnipeg, Manitoba R3E 0V9

MG-836

Formule 3
(Article 7)

Province du Manitoba

Médecin Date

Jour| Mois |Année

Adresse

RAPPORT DE TUMEUR MALIGNE
en vertu de la Loi sur la santé publique

IDENTIFICATION DU PATIENT

Nom de famille M. [ ] Mme [ ] Mlle [ ]

Prénom Initiales

Nom de fille (s'il y a lieu) Initiales de l'époux

N° app. N° civique Rue

Ville Province

État civil :
Célibataire [ ] Marié [ ] Veuf [ ] Séparé [ ]
Divorcé [ ]

Date de naissance Jour	Mois	Année	CAMH n°

TRAITEMENT

Type du premier traitement administré le Jour | Mois | Année

Endroit (nom, hôpital, bureau, etc.)

Traitement subséquent Jour | Mois | Année

Endroit

Patient référé à

Autre cancer antérieur? Si oui, indiquer la date Jour | Mois | Année et site primaire

DIAGNOTIC DE CANCER COURANT

Diagnostic de cancer

Site primaire

Histologie

Moyen(s) diagnotique(s)

Pathologique [ ] Clinique [ ]

Cytologique [ ] Autopsie [ ] seulement

Radiographique [ ] ou par balayage cathodique [ ] Mammographie [ ]

Autre

Stage

T(tumeur)

N(nodule)

M (métastase)

Date 1er diag Jour | Mois | Année

ÉTAT COURANT DU PATIENT

Le médecin à contacter pour le suivi annuel est :

Dr Nom

Adresse

Dernière visite Jour | Mois | Année — État du cancer à ce moment-là

Si le patient est décédé : Date du décès Jour | Mois | Année — Lieu du décès

Cause du décès

Autopsie ?
Oui [ ] Non [ ]

COMMENTAIRES

Signature du médecin

La présente formule doit être remplie une fois lors du premier diagnostic de cancer et à nouveau pour chaque nouveau cancer primaire.
Faire parvenir à : Enregistrement des cancéreux
Fondation manitobaine du cancer
700, avenue Bannatyne, Winnipeg (Manitoba) R3E 0V9

MG-836

FORM 4
(Section 8(2))

FRONT

This form should be completed at the end of each month and sent to:
The Director,
Communicable Disease Control,
Third Floor, 831 Portage Avenue
Winnipeg, Manitoba R3G 0N6

_____ ;

MONTHLY REPORT OF COMMUNICABLE DISEASES

NAME OF HOSPITAL _____ ADDRESS _____

Particulars of Patients who were treated for COMMUNICABLE DISEASES in your hospital during the

Month of _____ 19 _____

For a list of communicable diseases to be reported, please see guide on reverse. It will be appreciated if **Rare Diseases** and cases of **Typhoid, Diphtheria** or **Meningococcal** infections are reported by telephone to: Communicable Disease Control, Winnipeg, 945-6834 or 1-800-782-8402.

NAME	AGE	SEX	ADDRESS	DIAGNOSIS	DATE OF ONSET

DATE _____

_____ADMINISTRATOR

FORM 4
(BACK)

Please Report Rare Diseases and cases of Typhoid, Diphtheria or Meningococcal Infections by telephone to:
Communicable Disease Control
Winnipeg 945-6834 or 1-800-782-8402.

NOTIFIABLE DISEASE REPORTING GUIDE FOR THE PROVINCE OF MANITOBA
List of Notifiable Diseases

A. COMMON DISEASES

Intestinal Infectious Diseases
- E. coli Enteritis
- Food Poisoning (bacterial)
  - (excluding Botulism)
  - Bacillus cereus
  - Clostridium perfringens
  - Other Clostridia
  - Salmonellosis, Shigellosis
  - Staphylococcal
  - Vibrio parahaemolyticus
  - Unspecified
- Paratyphoid fever
- Salmonellosis, Shigellosis
- Typhoid fever

Tuberculosis
1. Primary Tuberculosis
2. Bacteriologically Confirmed
   - (a) Respiratory
   - (b) Non-Respiratory
3. Not Bacteriologically Confirmed
   - (a) Respiratory
   - (b) Non-Respiratory

Sexually Transmitted Diseases
- Acquired immunodeficiency syndrome (AIDS)
- Chancroid
- Chlamydia
- Gonorrhea
- Syphilis

Other Bacterial Diseases
- Rocky Mountain Spotted Fever
- Brucellosis
- Diphtheria Cases
- Diphtheria Carriers
- Meningococcal infections
- Pertussis

Other Viral Diseases
- Congenital Rubella
- Hepatitis A
- Hepatitis B
- Measles
- Mumps
- Rubella

Diseases of Central Nervous System
- Meningitis
  1. Bacterial
     - Haemophilus
     - Pneumococcal
     - Other (All categories excluding Meningococcal and Tuberculous)
  2. Viral
     - Aseptic meningitis due to Coxsackie
     - Echo virus
     - Other viral
- Encephalitis
  - Western equine encephalitis

B. RARE DISEASES

- Amoebiasis
- Anthrax
- Botulism
- Cholera
- Lassa Fever
- Leprosy
- Malaria
- Plague
- Poliomyelitis
- Psittacosis
- Rabies
- Tetanus
- Trichinosis
- Tularaemia
- Viral Haemorrhagic fever
- Yellow Fever

C. EPIDEMIC FORMS OF OTHER DISEASES AND UNUSUAL CLINICAL MANIFESTATIONS NOT OTHERWISE REPORTED

D. DISEASES REPORTABLE BY HOSPITALS

- Glomerulonephritis, post streptoccal
- Rheumatic fever

E. DISEASES REPORTABLE BY LABORATORIES

- Campylobacter Infections
- Giardiasis
- Human Immunodeficiency Virus Infection
- Legionnaire's Disease
- Parasitic Diseases, other
- Q-fever
- Relapsing Fever
- Rotavirus Infection
- Yersinia Infections

Formule 4
(Paragraphe 8(2))

RECTO

La présente formule doit être remplie
à la fin de chaque mois et transmise
à l'adresse suivante :
Le Directeur,
Contrôle des maladies contagieuses,
3e étage, 831 avenue Portage
Winnipeg (Manitoba) R3G 0N6 ;

RAPPORT MENSUEL DE MALADIES CONTAGIEUSES

NOM DE L'HÔPITAL _____ ADRESSE _____

Détails relatifs aux patients traités à votre hôpital pour des MALADIES CONTAGIEUSES pendant

le mois de _____ 19 _____

Pour la liste des maladies contagieuses à déclarer, prière de consulter le guide au verso. Nous vous saurions gré de signaler les cas de MALADIES RARES, de TYPHOIDE, de DIPHTÉRIE et d'infections à MÉNINGOCOQUES par téléphone au : Contrôle des maladies contagieuses, Winnipeg, 945-6834 ou 1-800-782-8402.

NOM	ÂGE	SEXE	ADRESSE	DIAGNOSTIC	DATE DU DÉBUT

DATE _____

_____ADMINISTRATEUR

Formule 4
(VERSO)

Prière de signaler par téléphone les maladies rares ainsi que les cas de typhoide, de diphtérie et d'infections à méningocoques au :
Contrôle des maladies contagieuses
Winnipeg 945-6834 ou 1-800-782-8402.

GUIDE DES MALADIES À DÉCLARER POUR LA PROVINCE DU MANITOBA
List des maladies à déclarer

A. MALADIES COMMUNES

Maladies infectieuses intestinales
- Entérite à E. coli
- Fièvre paratyphoide
- Fièvre typhoide
- Salmonellose
- Shigellose
- Toxi-infection alimentaire (bactérienne) (sauf le botulisme, la salmonellose, la shigellose)
  - à Bicillus cereus
  - à Clostridium perfringens
  - à autres Clostridia
  - à staphylocoques
  - à Vibrio parahaemolyticus
  - (sans précision)

Tuberculoses
1. Tuberculoses primaire
2. Confirmée bactériologiquement
   (a) Respiratoire
   (b) Non respiratoire
3. Non confirmée bactériologiquement
   (a) Respiratoire
   (b) Non respiratoire

Maladies à transmission sexuelle
- Chancre mou
- Chlamydia
- Gonorrhée
- Syndrome d'immuno-déficience acquise (SIDA)
- Syphilis

Autres maladies bactériennes
- Brucellose
- Cas de diphtérie
- Coqueluche
- Fièvre pourprée des montagnes rocheuses
- Infections à méningoques
- Porteurs de diphtérie

Autres maladies virales
- Hépatite A
- Hépatite B
- Oreillons
- Rougeole
- Rubéole
- Rubéole congénitale

Maladies du système nerveux central
- Méningite
  1. bactérienne
     - à Haemophilus
     - à Pneumocoques due à d'autres maladies bactériennes (toutes catégories sauf à méningocoques et tuberculeuses)
  2. Virale
     - Méningite aseptique due au virus de Coxsachie au virus ECHO
     - Autres méningites virales
- Encéphalite
  - Encéphalite équine occidentale

B. MALADIE RARES
- Amibiase
- Botulisme
- Charbon bactérien
- Choléra
- Fièvre de Lassa
- Fièvre hémorragique virale
- Fièvre jaune
- Lèpre
- Malaria
- Peste
- Poliomyélite
- Psittacose
- Rage
- Tétanos
- Trichinose
- Tularémis
- Variole

C. FORMES ÉPIDÉMIQUES D'AUTRES MALADIES ET MANIFESTATIONS CLINIQUES INHABITUELLES NON DÉCLARÉES AUTREMENT

D. MALADIES À DÉCLARER PAR LES HÔPITAUX
- Glomérulonéphrite, post streptococcique
- Fièvre rhumatismale

E. MALADIES À DÉCLARER PAR LES LABORATOIRES
- Autres maladies parasitaires
- Fièvre de Queensland
- Fièvre récurrente
- Giardiase
- Infection à rotovirus
- Infections à campylobactère
- Infection à yersinia
- Infection au virus de l'immunodéficience humaine (VIH)
- Maladie du légionnaire

Form 5
(Section 9)

Notification of Death from Notifiable Disease

Manitoba Health

PROVINCE OF MANITOBA

under The Public Health Act

Communicable Disease Control

PLEASE PRINT - PRESS HARD :

Full Name _____

Address _____
City, Street and No. Sec. Tp. and Range

Sex _____ Age _____

Date of Death _____ 19 _____

Place of Death _____
City, Street and No. (Sec. Tp. and Range) Hospital or Camp

Signature _____

Address _____

Date _____ 19 _____

AS A CASE OF (Underline)

Intestinal Infectious Diseases

·Typhoid fever
Paratyphoid fever
Salmonella infections
Shigellosis
·Food poisoning (bacterial)
Staphylococcal
Botulism
C. perfringens
B. cereus
Other (specify below)
E. coli enteritis

Other Bacterial Diseases

Brucellosis
·Diphtheria cases
Diphtheria carriers
·Meningococcal infections
Pertussis
Sexually Transmitted Diseases - Use STD Form
Tuberculosis - specify type below

Diseases of Central Nervous System

Heningitis
A. Bacterial
Haemophilus
Pneumococcal
Other (specify below)
B. Viral
Aseptic meningitis due to Coxsackie
Echo virus
Other viral (specify below) or unknown
Encephalitis
Western Equine Encephalitis
Other Viral Encephalitis (specify)

Other Viral Diseases

Hepatitis A
Hepatitis B
Measles
Mumps
Rubella
Congenital Rubella

OTHER DISEASES INCLUDING RARE· AND IMPORTED· (SPECIFY)

ADDITIONAL INFORMATION_____

Diagnosis confirmed by autopsy Yes _____ No _____

Mail to: Communicable Disease Control

Sealed in the Special Addressed Envelope Provided for the Purpose.

Formule 5
(Article 9)

Avis du décès causé par une maladie à déclarer

Santé Manitoba

PROVINCE DU MANITOBA

en vertu de la Loi sur la santé publique

Contrôle des maladies contagieuses

ÉCRIRE EN CARACTÈRES D'IMPRIMERIE – APPUYER FORTEMENT

Nom au complet _____

Adresse _____
Ville, rue et n°, sec., tp. et rang

Sexe _____ Âge _____

Date du décès _____ 19 _____

Endroit du décès _____
Ville, rue et n° (sec., tp. et rang) hôpital ou camp

Signature _____

Adresse _____

Date _____ 19 _____

Maladies infectieuses intestinales

*Fièvre typhoïde
Fièvre paratyphoïde
Infections à salmonellose
Shigellose
*Toxi-infection alimentaire(bactérienne)
à staphylocoques
botulisme
à C. perfringens
à B. Cereus
Autres (préciser ci-dessous)
Entérite à E. coli

Autres maladies bactériennes

Brucellose
*Cas de diphtérie
Coqueluche
*Infections à méningocoques
Maladies à transmission sexuelle (utiliser la formule MTS)
Porteurs de diphtérie
Tuberculose
(préciser le genre ci-dessous)

Maladies du système nerveux central

Méningite
A. Bactériale
à Haemophilus
à pneumocoques
Autres (préciser ci-dessous)
B. Virale
Méningite aseptique due au virus de Coxsachie
Virus ECHO
Autres méningites virales(préciser) ou inconnues
Encéphalite
Encéphalite équine occidentale
Autre encéphalite virale
(préciser)

Autres maladies virales

Hépatite A
Hépatite B
Oreillons
Rougeole
Rubéole
Rubéole congénitale

AUTRES MALADIES, Y COMPRIS LES MALADIES RARES* ET IMPORTÉES* (PRÉCISER)

_____

RENSEIGNEMENTS ADDITIONNELS _____

Diagnostic confirmé par autopsie Oui _____ Non _____

Poster à : Contrôle des maladies contagieuses

Scellé dans l'enveloppe pré-adressée fournie à cette fin.

FORM 6
(Section 29)

CAUTION: Turtles may transmit disease-causing bacteria to humans. It is important to wash the hands thoroughly after handling turtles or material in a turtle bowl, not to allow water or any other substance from a turtle bowl to come in contact with your food or areas where your food is prepared, and to make sure that these precautions are followed by children or others handling turtles.

FORMULE 6
(article 29)

ATTENTION : Les tortues peuvent transmettre aux humains des bactéries susceptibles de causer des maladies. Il est donc important de se laver les mains à fond après avoir manipulé des tortues ou du matériel qui se trouve dans leur bassin, d'éviter que l'eau ou toute autre substance provenant d'un bassin de tortue ne vienne en contact avec les aliments ou les endroits où ceux-ci sont préparés et de s'assurer que ces précautions sont suivies par les enfants et par les autres personnes qui manipulent des tortues.

FORM 7
(Subsection 43(2))

Notification of Sexually Transmitted Diseases Confidential

Manitoba Health
Sexually Transmitted Disease Control

3rd Floor, 800 Portage Ave
Winnipeg, Manitoba
R3G 0N4
(204) 945-6791

Room No. (Leave Blank)

NAME (SURNAME) | ADDRESS | POSTAL CODE | TELEPHONE HOME / WORK

GIVEN NAME | MARRIED COMMON LAW | MAIDEN NAME IF APPLICABLE | SPOUSE'S FIRST NAME

DATE OF BIRTH __/__/__ Y M D | DATE TESTED __/__/__ Y M D

SEX MALE FEMALE | ONSET __/__/__ Y M D

GONORRHEA CHLAMYDIA
TYPE: GENITO-URINARY OTHER (SPECIFY)
CLINICAL FINDINGS (DESCRIBE)
DURATION OF SYMPTONS
LABORATORY TESTS:
SMEAR POS NEG CULTURE POS NEG
GONOZYME POS NEG CHLAMDIAZYME POS NEG
HAS A BLOOD TEST BEEN TAKEN FOR SYPHILIS YES NO
TREATMENT GIVEN (SPECIFY)
DATE __/__/__ Y M D
PREVIOUS TREATMENT FOR: GONORRHEA YES NO
CHLAMYDIA YES NO
DATE __/__/__ Y M D

SYPHILIS
TYPE: PRIMARY SECONDARY EARLY LATEN LATE LATENT
CARDIOVASCULAR NEUROSYPHILIS CONGENITAL
TREATMENT GIVEN (SPECIFY)
DATE __/__/__ Y M D
DIAGNOSIS BASED ON:
DARKFIELD DFA-TP POS NEG SCREEN POS NEG
CONFIRMATORY POS NEG REFERENCE POS NEG
CEREBROSPINAL FLUID POS NEG NOT DONE
CLINICAL FINDINGS
(DESCRIBE)
PREVIOUS TREATMENT FOR SYPHILIS YES NO
BY WHOM
DATE __/__/__ Y M D
OTHER SEXUALLY TRANSMITTED DISEASES
AIDS CHANCROID LGV

DO YOU WISH: DRUGS (AMOUNT)
CONSULTATIVE SERVICE NOTIFICATION FORMS PATIENT LITERATURE
PHYSICIAN'S SIGNATURE ADDRESS

CONFIDENTIAL

Contact Information

Manitoba Health
Sexually Transmitted Disease Control

3rd Floor, 800 Portage Ave
Winnipeg, Manitoba
R3G 0N4
(204) 945-6791

NAME | MAIDEN NAME | TELEPHONE HOME / WORK

ADDRESS | POSTAL CODE | DATE OF BIRTH | AGE | FEMALE MALE

MARITAL STATUS MARRIED SINGLE OTHER | WHERE LIVING PARENTS INFORMANT OTHER

OCCUPATION | PLACE OF EMPLOYMENT

RELATIONSHIP MARITAL PICK-UP FRIEND PROSTITUTE FEE
CHARACTERISTICS HEIGHT WEIGHT EYE COLOUR HAIR COMPLEXION OTHER
PLACE OF MEETING | PLACE OF EXPOSURE
DATE OF EXPOSURE (FIRST): TO
FREQUENCY OF SEX CONTACT
TYPE O-G G-G R-G
REMARKS:

FOR PUBLIC HEALTH USE ONLY DATE WK
NAME OF INFORMANT PAGE
ADDRESS
DATE/TYPE SPECIMEN
GONORRHEA CHLAMYDIA SYPHILIS OTHER

RESULT OF EXAMINATION

DATE	STS BLOOD/CSF	GC SMEARR/CULTURE	CHLAMYDIA TEST	CLININCAL FINDINGS	TREATMENT

EXAMINED BY SUBMITTED BY
COMMENTS

CONFIDENTIAL

Contact Information

Manitoba
Health
Sexually Transmitted
Disease Control

3rd Floor 800 Portage Ave
Winnipeg Manitoba
R3G 0N4
(204) 945-6791

NAME MAIDEN NAME TELEPHONE HOME WORK

ADDRESS POSTAL CODE DATE OF BIRTH AGE ___ FEMALE ___ MALE

MARITAL STATUS __ MARRIED __ SINGLE __ OTHER_____ WHERE LIVING __ PARENTS __ INFORMANT __ OTHER_____

OCCUPATION _____ PLACE OF EMPLOYMENT _____

RELATIONSHIP __ MARITAL __ PICK-UP __ FRIEND __ PROSTITUTE FEE _____

CHARACTERISTICS HEIGHT_____ WEIGHT_____ EYE COLOUR_____ HAIR_____ COMPLEXION_____ OTHER_____

PLACE OF MEETING _____ PLACE OF EXPOSURE _____

DATE OF EXPOSURE (FIRST): _____ TO _____

FREQUENCY OF SEX CONTACT _____

_____ TYPE O-G _____ G-G _____ R-G

REMARKS: _____

FOR PUBLIC HEALTH USE ONLY DATE _____ WK _____

NAME OF INFORMANT _____ PAGE _____

ADDRESS _____

DATE/TYPE SPECIMEN _____

__GONORRHEA __ CHLAMYDIA __ SYPHILIS __OTHER_____

RESULT OF EXAMINATION

DATE	STS BLOOD/CSF	GC SMEARR/CULTURE	CHLAMYDIA TEST	CLININCAL FINDINGS	TREATMENT

EXAMINED BY _____ SUBMITTED BY _____

COMMENTS _____

CONFIDENTIAL

FORMULE 7
(Subsection 43(2))

Déclaration de maladies transmises sexuellement

Santé Manitoba
Contrôle des maladies transmises sexuellement

800, avenue Portage
3e étage
Winnipeg (Manitoba)
R3G 0N6
(204) 945-6791

N° de commande (laisser en blanc)

NOM (PRÉNOM)
PRÉNOM
DATE DE NAISSANCE j m a
SEXE FÉMININ MASCULIN

ADRESSE
CODE POSTAL
__MARIÉ(E) CONJOINT DE ; FAIT PRÉNOM DU CONJOINT
____ NOM DE JEUNE FILLE (le cas échéant)

N° DE TÉLÉPHONE
DOMICILE
TRAVAIL
DATE DES EXAMENS j m a
DATE DU DÉBUT DE LA MALADIE j m a

__GONORRHÉE __CHLAMYDIA
TYPE: _GÉNITO-URINAIRE _AUTRE (PRÉCISER)___
RÉSULTATS CLINIQUES (décrire) _____
_____DURÉE DES SYMPTÔMES _____
ÉPREUVES DE LABORATOIRE
FROTTIS __POS.__NÉG. CULTURE __POS. __NÉG.
GONOZYME __POS.__NÉG.CHLAMDIAZYME __POS.__NÉG.
PRISE DE SANG POUR DÉTECTER LA SYPHILIS
___OUI ___NON
TRAITEMENT ADMINISTRÉ (PRÉCISER)_____
_____DATE __/__/__/__
j m a
TRAITEMENT ADMINISTRÉ ANTÉRIEUREMENT EN CAS DE
GONORRHÉE __OUI __NON
CHLAMYDIA __OUI __NON
DATE __/__/__/__
j m a

___SYPHILIS
TYPE: __ PRIMAIRE __ SECONDAIRE
__ RÉCENTE LATENTE __ TARDIVE LATENTE
__CARDIOVASCULAIRE __NEUROSYPHILIS __ CONGÉNITALE
TRAITEMENT ADMINISTRÉ (PRÉCISER)_____
_____DATE __/__/__/__
j m a
ÉPREUVES DE LABORATOIRE
ULTRAMICROSCOPE
ÉPREUVE IFD - __ POS. __ NÉG. DÉPISTAGE __POS.__NÉG.
CONFIRMATION __POS. __NÉG. COMPARAISON __POS.__NÉG.
LIQUIDE CÉPHALO-RACHIDIEN _POS. _NÉG. _PAS ADMINISTRÉ
RÉSULTATS CLINIQUES_____
(décrire)_____
TRAITEMENT ADMINISTRÉ ANTÉRIEUREMENT
EN CAS DE SYPHILIS :__OUI __ NON
DATE __/__/__/__
j m a
MÉDECIN TRAITANT
AUTRES MALADIES TRANSMISES SEXUELLEMENT
___ SIDA ___ CHANCRE ___ LV

LE MÉDECIN DÉSIRE-T-IL ADMINISTRER DES MÉDICAMENTS (QUANTITÉ) _____
__ RECEVOIR DES SERVICES DE CONSULTATION __ RECEVOIR DES FORMULES DE DÉCLARATION __ RECEVOIR DE LA DOCUMENTATION À L'INTENTION DES MALADIES
SIGNATURE DU MÉDECIN
ADRESSE
CONFIDENTIEL

Renseignement sur les partenaires

Santé Manitoba
Contrôle des maladies transmises sexuellement

800, avenue Portage
3e étage
Winnipeg (Manitoba)
R3G 0N6
(204) 945-6791

NOM
NOM DE JEUNE FILLE
N° DE TÉLÉPHONE
DOMICILE
TRAVAIL
ADRESSE
CODE POSTAL
DATE DE NAISSANCE/ÂGE
SEXE __ FÉMININ __ MASCULIN
ÉTAT CIVIL __ MARIÉ(E) __ CÉLIBATAIRE __ AUTRE
HABITE __ CHEZ LES PARENTS __ CHEZ L'INFORMATEUR __AILLEURS
OCCUPATION
ADRESSE DE L'EMPLOYEUR
RELATION CONJOINT __ RENCONTRE __ AMI __ PROSTITUÉ(E) TARIF
CARACTÉRISTIQUES : TAILLE __ POIDS __ COULEUR DES YEUX __ COULEUR DES CHEVEUX __ COULEUR DE LA PEAU __ AUTRES RENSEIGNEMENTS __
LIEU DE LA RENCONTRE
LIEU DE LA RELATION SEXUELLE
DATE DE LA RELATION SEXUELLE (PREMIÈRE) _____ (DERNIÈRE) _____
FRÉQUENCE DES RELATIONS SEXUELLES _____
_____ TYPE O-G _____ G-G _____ R-G
OBSERVATIONS : _____

RÉSERVÉ À LA DIRECTION DE LA SANTÉ PUBLIQUE
DATE _____ SEMAINE _____
PAGE _____
NOM DE L'INFORMATEUR
ADRESSE
__ GONORRHÉE __ CHLAMYDIA __ SYPHILIS __AUTRE

RÉSULTATS DES ÉPREUVES

DATE	EXAMEN SÉROLOGIQUE-SYPHILIS/LCR	FROTTIS GONOCOQUE/CULTURE	ÉPREUVE-CHLAMYDIA	RÉSULTATS CLINIQUES	TRAITEMENT

EXAMINÉ PAR :
PRÉSENTÉ PAR :
REMARQUES :
CONFIDENTIEL

Renseignement sur les partenaires

Santé Manitoba
Contrôle des maladies transmises sexuellement

800, avenue Portage
3e étage
Winnipeg (Manitoba)
R3G 0N6
(204) 945-6791

NOM NOM DE JEUNE FILLE N° DE TÉLÉPHONE DOMICILE TRAVAIL

ADRESSE CODE POSTAL DATE DE NAISSANCE/AGE SEXE __ FÉMININ MASCULIN

ÉTAT CIVIL __ MARIÉ(E) __ CÉLIBATAIRE __ AUTRE ; HABITE CHEZ LES __ PARENTS CHEZ __ L'INFORMATEUR __AILLEURS

OCCUPATION _____ ADRESSE DE L'EMPLOYEUR _____

RELATION __ CONJOINT __ RENCONTRE __ AMI __ PROSTITUÉ(E) TARIF _____

CHARACTÉRISTIQUES : TAILLE __ POIDS __ COULEUR DES YEUX __ COULEUR DES CHEVEUX __ COULEUR DE LA PEAU __ AUTRES RENSEIGNEMENTS __

LIEU DE LA RENCONTRE _____ LIEU DE LA RELATION SEXUELLE _____

DATE DE LA RELATION SEXUELLE (PREMIÈRE) _____ (DERNIÈRE) _____

FRÉQUENCE DES RELATIONS SEXUELLES _____

TYPE O-G _____ G-G _____ R-G

OBSERVATIONS : _____

RÉSERVÉ À LA DIRECTION DATE _____ SEMAINE _____

DE LA SANTÉ PUBLIQUE PAGE _____

NOM DE L'INFORMATEUR _____

ADRESSE

GONORRHÉE __ CHLAMYDIA __ SYPHILIS __AUTRE _____

RÉSULTATS DES ÉPREUVES

DATE	EXAMEN SÉROLOGIQUE-SYPHILIS/LCR	FROTTIS GONOCOQUE/CULTURE	ÉPREUVE-CHLAMYDIA	RÉSULTATS CLINIQUES	TRAITEMENT

EXAMINÉ PAR : _____ PRÉSENTÉ PAR : _____

REMARQUES :

CONFIDENTIEL

FORM 8
(Section 48)

Order for a Medical Examination of a Person by a Physician

Manitoba Health
The Public Health Act And Regulations

TO:_____ Date of Birth:____/____/____
(Year-Month-Day)

OF:_____ : _____
(Occupation)

WHEREAS, on the basis of information received by me,
I believe that
(a) you have or may have a sexually transmitted disease; or
(b) you have been or may have been in contact with another person who has a sexually transmitted disease, under circumstances from which it reasonably can be expected that the infected person may have transmitted the disease to you;
and should be examined by a physician to ascertain if you have a sexually transmitted disease.

NOW THEREFORE, pursuant to The Public Health Act and regulations, I DO ORDER;
(1) THAT you,_____shall consult and be examined by_____a physician.

(2) THAT you present yourself to the said physician at_____
(address) on or before the_____ day of_____,
19____, between_____ and _____.

(3) THAT if you are found on examination to be infected with a sexually transmitted disease, you do, within _____ days after the completion of the examination mentioned in paragraph (1) of this order, present yourself to the physician named above, or to some other physician, and take treatment for the sexually transmitted disease and continue to receive treatment until you no longer have the sexually transmitted disease in its infectious form, as determined by the Director of Communicable Disease Control.

DATED at_____this_____day of_____, 19__

_____ OR _____
Medical Officer of Health Director of Communicable Disease Control

_____ _____
Address Address

FORMULE 8
(article 48)

Ordre d'examen médical d'une personne par un médecin

Ministère de la Santé du Manitoba
La Loi sur la santé publique et ses règlements d'application

À : _____ Date de naissance : ____/____/____
(jour-mois-année)

DE : _____ : _____
(Profession)

ATTENDU QUE, sur la foi des renseignements qui m'ont été communiqués, j'estime que vous êtes dans l'une ou l'autre des situations suivantes :

a) vous souffrez ou êtes susceptible de souffrir d'une maladie transmise sexuellement;

b) vous avez été ou avez pu être en contact avec une personne qui souffre d'une maladie transmise sexuellement, dans des circonstances où on peut raisonnablement s'attendre à ce que la personne contaminée vous ait transmis la maladie;

et que vous devriez être examiné par un médecin afin de déterminer si vous souffrez d'une maladie transmise sexuellement.

EN CONSÉQUENCE, conformément à la Loi sur la santé publique et à ses règlements d'application, J'ORDONNE :

(1) QUE vous, _____, consultiez _____, médecin, et que vous soyez examiné par lui.

(2) QUE vous vous rendiez chez ce médecin au _____ au plus tard
(adresse)
le _____ 19___, entre _____ et _____.

(3) QUE, si l'examen révèle que vous souffrez d'une maladie transmise sexuellement, vous vous rendiez, dans les _____ jours qui suivent l'examen mentionné à l'alinéa (1) du présent ordre, chez le médecin susmentionné ou chez un autre médecin, afin d'être traité pour la maladie transmise sexuellement jusqu'à ce que vous n'ayez plus la maladie transmise sexuellement dans sa forme infectieuse, déterminée par le directeur du contrôle des maladies contagieuses.

FAIT à _____ le _____ 19___
(date)

_____ OU _____
Médecin hygiéniste Directeur du contrôle des maladies contagieuses

_____ _____
Adresse Adresse

FORM 9
(SECTION 57)

TRANSPORTATION OF REMAINS OF DECEASED PERSON

Certificate of Embalmer or Funeral Director

Certificate No.

I hereby certify that this case contains the dead body of
of ; who died on the day
of 19 . The necessary registration of death has been made and the said body has been prepared and other related procedures complied with in accordance with the laws of the Province of Manitoba.

Transportation by Common Carrier.

Approved.

(Print Name of Embalmer or Funeral Director)
Signature
Licence Number

FORMULE 9
(article 57)

TRANSPORT DES RESTES D'UNE PERSONNE DÉCÉDÉE

Certificat d'embaumeur ou d'entrepreneur de pompes funèbres

Certificat n°

J'atteste que le présent contenant renferme le cadavre de
de qui est décédé(e) le 19 . Les formalités nécessaires d'enregistrement du décès ont été effectuées et la préparation du corps ainsi que les autres procédures connexes ont été faites conformément aux lois de la province du Manitoba.

Transport par transporteur public.

Autorisé.

(Écrire en majuscules le nom de l'embaumeur ou de l'entrepreneur de pompes funèbres)
Signature
Numéro de permis

SCHEDULE B
(Section 24)

PROCEDURES FOR NOTIFIABLE DISEASES

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Amoebiasis	Exclusion of patient from preparation, processing and serving food until treatment is is completed. Surveillance during the carrier state.	None	None	None	Sanitary disposal of feces, hand washing after defecation.	Required	Where several cases occur in an area or institution the medical officer of health shall take measures to ensure that there is no contamination of water and food supply.
Anthrax	Until Lesions are bacteriologically free of anthrax bacilli	None	None	None	Of discharge from lesions and articles soiled therewith.	Required	The medical of health shall search for history of exposure to infected animals or contaminated animal products (Isolation of infected animals is required and notification to the Health of Animals Division, Department of Agriculture, Canada)
Aseptic Meningitis	Required during the period of fever	None	Not Required	None	Of eating and drinking utensils and articles soiled by secretions and excretions of patient	None	None

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Bacillary Dysentery	Isolation is required during the acute illness. Surveillance and prohibition from food handling of carriers.	Contacts should not be employed as food handlers during the period of contact nor until 3 negative faeces cultures are obtained.	None	None	Sanitary disposal of faeces	Required	Where an epidemic occurs the medical officer of health shall take measures to ensure pure food, water and milk supplies and have a search carried out for unrecognized mild cases and carriers.
Botulism	None	None	Those who have eaten the suspected food should be promptly given botulinus antitoxin.	None	None	None	The medical officer of health shall search for persons who shared suspected food and for any remaining food from same source. This should be carefully collected for laboratory examination.
Brucellosis (Undulant fever)	None	None	None	None	of body discharges	None	The medical officer of health may stop distribution of unpasteurized milk if patient infected through this source.
Cancer	None	None	None	None	None	None	Nil
Chickenpox	Isolation at home and exclusion from school from the onset of the disease until 7 days after the appearance of the first crop of vesicles	None	None	Exclude	Of Articles non-immune children from contact.	None by discharges from the nose and throat and from lesions	Nil
Cholera	In hospital or fly screened room during communicable period.	For five days from last exposure and until faeces contains no cholera vibrios	Not required, cholera vaccine is however recommended for exposed population groups	Required	Of feces and vomitus and of articles used by patient. Scrupulous cleanliness is required of attendants	Required	The medical officer of health shall investigate possibilities of infection from polluted drinking water or uncooked food (He or she shall assure adequate treatment of water by chlorination or boiling. Case report required by International Sanitary Regulations)

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Diarrhoea of the Newborn (Epidemic)	Infected infants and suspects should be isolated during the period of communicability	Required of all newborn contacts	None	Required	Of all discharges and articles soiled therewith	Required	Two or more concurrent cases in a nursery are to be interpreted as an epidemic
Diphtheria	Clinical and suspected cases of diphtheria must be isolated until clinical recovery and until 2 or more cultures from the throat and 2 or more from the nose taken not less than 24 hours apart fail to show diphtheria bacilli. Isolation may be terminated if the micro-organism is proved to be avirulent.	Required for all intimate contacts until proven to be bacteriologically negative, after termination of contact with the case or carrier.	Child contacts less than 10 years age, intimately exposed and not previously immunized with Toxoid, may be given a prophylactic dose of antitoxin 10,000 units and at the same time given a first dose of Toxoid. Persons previously immunized should have a reinforcing dose of Toxoid	Required until released from quarantine by the medical officer of health.	Of all articles in contact with the patient and all articles soiled by discharges	Required	Carriers of diphtheria shall be isolated in the same manner as cases. The medical officer of health may require all contacts of a case, suspect case or carrier of diphtheria to submit a throat and nose swab for bacteriological examination. Swabs may also be required of students attending a school in which there has been a case, suspect case or carrier of diphtheria. In the event of an outbreak of diphtheria, the medical officer of health may offer active immunization to all susceptible persons in the area affected by the outbreak.
Hepatitis (Infectious)	During first week of illness	None	Family contacts may be given immune serum globulin 0.02 ml. per pound of body weight.	None	Feces, and nose and throat secretions	None	The medical officer of health shall ensure that arrangements are made for the sanitary disposal of feces
Hepatitis. (Serum)	None	None	None	None	Of equipment contaminated with blood	None	The medical officer of health may require thorough heat sterilization of syringes and needles used for injections and of stylets for finger punctures and that a fresh sterile syringe and needle or stylet should be used for each patient

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Influenza	Not required unless ordered by the medical officer of health	None	Not required	Not required	Discharges from the nose and throat of the patient	None	None
Leprosy	Isolation until released by the medical officer of health	None	None	None	Discharges of lesions and articles soiled therewith	Required	The medical officer of health may require isolation in a hospital or colony until bacteriologically negative for at least six months
Malaria	None	None	None	None	None	None	N.B. Mosquitoes in Manitoba are not known to act as vector of malaria and therefore the disease cannot normally be spread in this province
Measles	From onset of illness until 4 days after appearance of rash	Required for school pupils; incubation period is 14 days	Not required except for the purposes of section 260.1 of Public Schools Act	Exclude non-imune children	All articles soiled with secretions of nose and throat	Thorough cleaning required	Immunization required for school pupils as a prerequisite to first time admission to school
Meningococcal infections	Until 24 hours after start of chemotherapy or clinical recovery	None. The medical officer of health may require the quarantine of contacts unless they have had adequate prophylactic treatment with a suitable antibiotic or chemotherapeutic agent	None	None	Of discharges from the nose and throat and of articles soiled therewith	Thorough cleaning required	None
Mumps	Until swelling has subsided	None	Not required	Exclude non-immune children from contact	Of eating and drinking utensils, of articles soiled by secretions of nose and throat	None	None

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
				Disinfection			
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Plague	Required	Contacts shall undergo disinfestation and surveillance for 6 days	Not required	Required until disinfestation of rodents has been carried out to the satisfaction medical officer of health	Sputum and purulent discharges and articles soiled therewith, urine and feces of patients	Required and to be followed by fumigation to destroy rats and fleas	In the event of an outbreak the medical officer of health may require measures to be taken for the destruction of rats and fleas within the affected area (Case report required by International Sanitary Regulations)
Poliomuelitis myelitis	For one week from date of onset or for the duration of fever, if longer	Not required	Not required Community-wide use of live oral polio vaccine may be made available at the discretion of the medical officer of health	Non-immune Children and adults shall be excluded from contact	Of throat discharges and faeces and articles soiled therewith	Cleaning	In the event of an epidemic the medical officer of health may order the postponement of elective nose and throat operations, and of inoculation of any precipitated type antigen
Psittacosis (Ornithosis)	During acute febrile stage of the illness	None	None	The medical officer of health may quarantine pet shops where psittacosis has occurred until infected birds have been destroyed or treated to his or her satisfaction and the premises thoroughly cleaned	Of all discharges	Required of all buildings housing infected birds	The medical officer of health may order the destruction of flocks of turkeys or other birds where 40% of the flock are affected by a virus of high virulence and they cannot otherwise be treated to his or her satisfaction

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Rabies in Humans	For the duration of illness	None	None	None	Of saliva and articles soiled therewith	None	When an animal suspected of having rabies has bitten a human being the fact shall be immediately reported to the medical officer of health who shall secure or cause to be secured the animal alive and without injury, in a safe place. The animal shall be kept under observation for at least 10 days. If the animal develops signs of rabies or dies during the observation period the medical officer of health shall cause the head to be preserved in ice and sent to recognized laboratory for examination. (The occurrence of rabies in any animal must be reported to the Health of Animals Division, Canada Department of Agriculture)
Relapsing Fever (louse-borne)	Required until the patient, his or her clothing, all household contacts and the immediate environment have undergone disinfestation.	Required for 15 days unless they undergo disinfestation	None	Required until they have been disinfested	Disinfestation required		(Case report required by International Sanitary Regulation)
Rickettsial Infections (a) Typhus Louse-borne	Required until the patient, his or her clothing, living quarters, and household contacts have undergone disinfestation.	Required for 15 days unless they undergo disinfestation	Immediate contacts may be immunized	Required until they have been disinfested	Disinfestation required		(Case report required by International Sanitary Regulations)

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
(b) Rocky Mountain Spotted Fever	None	None	None	None	Destroy all ticks	Destroy all ticks	All ticks on the patient shall be destroyed
(c) Q Fever	None	None	Not required	None	Of sputum, excreta and blood and articles soiled therewith	None	None
Rubella (German Measles)	None	None	None	None	None	None	The patient shall not be allowed to come in contact with women who are in the early stages of pregnancy.
Salmonella Infections	Exclusion of infected persons from food handling and occupations involving care of young children until cultures of feces are free from salmonella	Family contacts shall not be employed as food handlers during the period of contact nor until 3 negative feces cultures are obtained	None	None	Sanitary disposal of feces	House-cleaning only required	Where an epidemic occurs the medical officer of health shall take measures to ensure pure food, water and milk supplies and having a search carried out for unrecognized mild cases and carriers
Sexually Transmitted Diseases							See Division II of this Regulation for the reporting and management of cases and contacts of sexually transmitted diseases.
Skin Disease Communicable (a) Pediculosis	Exclude from school until disinfested	None	None	None	None	None	Other members of family or associated groups shall be disinfested concurrently if infested.
(b) Impetigo	Exclude from school until adequately treated to the satisfaction of the medical officer of health	None	None	None	Of dressings, and moist discharges. Disinfect clothes, towels and sheets before laundering	Thorough cleaning	
(c) Ringworm	Exclude from school until adequately treated	None	None	None	Discharges, dressings and articles contaminated therewith	None	

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
(d) Scabies	Exclude from school until disinfested	None	None	None	None	None	The medical officer of health may require disinfection of other members of the family or associated groups. Underwear, sheets and blankets should be disinfested concurrently.
Staphylococcal Food Poisoning	None	None	None	None	None	None	The medical officer of health may search for food contaminated with staphylococci and the food handlers with skin infections or the nasal carrier state. He may order the destruction of any remainder of contaminated food after samples have been taken for laboratory examination.
Streptococcal Sore Throat and Scarlet Fever	Until complete clinical recovery or until the patient has been adequately treated with a suitable antibiotic or chemotherapeutic agent so as to render him or her non-infectious	None. The medical officer of health may require the quarantine of contacts unless they have had adequate prophylactic treatment with a suitable antibiotic or chemotherapeutic agent	Not required	None	Of purulent discharges and articles soiled therewith	Thorough cleaning	In the event of an epidemic where milk suspected as the vehicle of spread, the medical officer of health may prohibit the sale or use of milk which has not been pasteurized or otherwise treated to his or her satisfaction.
Tetanus	None	None	None	None	None	None	None
Trichinosis	None	None	None	None	None	None	The medical officer of health may seize and destroy any pork or pork products thought to be responsible for the infection

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Tuberculosis	Compulsory isolation may be required by the medical officer of health of those patients with infectious tuberculosis who cannot or will not take the necessary measures to avoid the spread of infection	None	Not required The medical officer of health may advise that tuberculin negative contacts to be given B, C, G, vaccine	Not normally required. The medical officer of health may quarantine premises if circumstances exist which, in his or her opinion, would tend to promote the spread of infection	Of sputum and articles soiled therewith, including handkerchiefs, cloth or paper napkins and of eating utensils used by the patient	Required	No person suffering from tuberculosis in an infectious state shall work in any industry, factory or business in which food or drink is prepared or offered for sale. No person having management, control, supervision or charge of any industry, factory or business in which food or drink is prepared or offered for sale shall permit, authorize or allow any person suffering from tuberculosis in an infectious state to work therein. No person with tuberculosis in an infectious state shall attend any school, seminary, college or university. No person, board or other body having the management, control, supervision or charge of any school, seminary, college or university shall permit, authorize or allow any person suffering from tuberculosis, in an infectious state to attend the school, seminary, college or university. No person suffering from tuberculosis, in an infectious state, will be employed in any occupation which involves the handling of or close contact with young children Where the medical officer of health suspects that milk or milk products may be concerned with the spread of tuberculosis, he may prohibit the sale or use of the milk or milk products until they have been pasteurized or otherwise treated to his or her satisfaction

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Tularemia	None	None	None	None	Of discharges from ulcer, lymph nodes or conjunctival sac	None	
Typhoid and Paratyphoid Fever	Required in fly proof room during the acute attack. If the medical officer of health is not satisfied that the patient can be satisfactorily isolated otherwise, he may require that the patient be isolated in a suitable hospital	Family contacts shall not be employed as handlers of food or or drink during the period of contact nor before 3 specimens of feces and urine have been found to be negative on culture for typhoid and paratyphoid organisms	Not normally required. The medical officer of health may advise that family, household and nursing contacts be immunized with a potent vaccine. The medical officer of health may refuse to release a a carrier of typhoid or paratyphoid from quarantine until such contacts have been immunized to his or her satisfaction	The medical officer of health may order the quarantine of premises until any measures to avoid the spread of infection that he or she directs have been taken to his or her satisfaction	Of feces and urine and articles soiled therewith	Required	The person who continues to discharge typhoid or paratyphoid bacilli three months after the date of onset of the disease shall be considered to be a carrier. A typhoid or paratyphoid carrier may be kept in quarantine unless he or she enters into an agreement with the Minister, on a form prescribed by the Minister, to conduct himself or herself in such a manner as to avoid the spread of infection. A person shall be considered to have ceased to be a carrier if 6 consecutive authenticated specimens of feces and urine, and of duodenal bile, taken one month apart are found to be negative. The medical officer of health may require the carrier to go to a public hospital to enable authentic specimens to be obtained. Where the medical officer of health suspects that a water supply may be concerned in an outbreak of typhoid or paratyphoid fever he or she may order that such water supply be not used unless it is chlorinated, boiled, or otherwise treated to his or her satisfaction. A medical officer of health who suspects that milk or milk products may be concerned in an outbreak of typhoid or paratyphoid fever may prohibit the sale or use of such milk or milk products until they have been pasteurized or otherwise treated to his or her satisfaction.

DISEASE	PATIENT	CONTACTS		PREMISES AND IMMEDIATE ENVIRONMENT			OTHER
					Disinfection		
	Isolation Requirements	Quarantine	Immunization	Quarantine	Concurrent	Terminal	
Western Equine Encephalitis	None	None	None	None	None	None	In the event of an epidemic the medical officer of health may take the necessary measures to eliminate mosquitoes
Whooping Cough	Separation of the patient from susceptible children and exclusion from school and public places for 3 weeks after onset of typical paroxysms	May return to school if kept under daily surveillance for three weeks	Not required. Routine immunization of all children against whooping cough is recommended	Exclude non-immune children from contact	Discharges from the nose and throat and articles soiled therewith	Thorough cleaning required	None
Yellow Fever	None	None	Not required	Access of mosquitoes to the patient during the first 3 days shall be prevented by the use of a bed net or a screened sickroom or by spraying quarters with an insecticide having a residual effect	None	None	(Case report required by International Sanitary Regulations)

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ANNEXE B
(article 24)

PROCÉDURES APPLICABLES AUX MALADES À DÉCLARER

MALADIE	PATIENT	CONTACTS		LOCAUX ET MILIEU IMMÉDIAT			AUTRES
					Désinfection		
	Exigences en matière d'isolement	Quarantaine	Immunisation	Quarantaine	Concomitante	Terminale	
Amibiase	Exclusion du patient des activités de préparation, de transformation et de service des aliments jusqu'à la fin du traitement. Surveillance du patient durant la phase porteur.	Aucune	Aucune	Aucune	Élimination salubre des fèces, lavage des mains après défécation.	Requise	Si plusieurs cas se présentant dans une région ou une institution, le médecin hygiéniste prend les mesures nécessaires pour prévenir la contamination des sources d'alimentation en eau et des approvisionnements alimentaires.
Botulisme	Aucune	Aucune	Les personnes ayant consommé des aliments suspects doivent rapidement se faire administrer l'antitoxine botulique.	Aucune	Aucune	Aucune	Le médecin hygiéniste recherche les personnes qui ont partagé les aliments suspects ainsi que les restes d'aliments provenant de la même source. Ces restes doivent être recueillis ave précaution pour fins d'analyse en laboratoire
Brucellose (Fièvre ondulante)	Aucune	Aucune	Aucune	Aucune	des pertes provenant du corps.	Aucune	Le médecin hygiéniste peut faire cesser la distribution de lait non pasteurisé si ce produit est la source de l'infection du patient.

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS	LOCAUX ET MILIEU IMMÉDIAT				AUTRES
		Quarantaine	Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	
Cancer	Aucune	Aucune	Aucune	Aucune	Aucuner	Aucune	Sans objet
Charbon bactérien	Jusqu'à ce que les lésions soient bactériologiquement libres de bacilles du charbon bactérien.	Aucune	Aucune	Aucune	des pertes provenant des lésions et des articles souillés par ces écoulements	Requise	Le médecin hygiéniste cherche s'il y a des antécédents d'exposition à des animaux infectés ou à des produits contaminés d'origine animale. (L'isolement des animaux infectés est requis, de même qu'un avis à la Division de la santé des animaux du ministère de l'Agriculture du Canada.)
Choléra	À l'hôpital ou dans une pièce munie de moustiquaire pendant la période de contagion.	Pendant cinq jours à compter de la dernière exposition et jusqu'à ce que les fèces ne contiennent plus de vibrions cholériques.	Non requise, le vaccin contre le choléra est cependant recommandé pour les groupes de population proposés.	Requise	des fèces, des vomissements et des articles utilisés par le patient. Les personnes qui soignent le patient doivent être scrupuleusement propres.	Requise	Le médecin hygiéniste vérifie les possibilités d'infection imputable à de l'eau de consommation ou à des aliments non cuits pollués (Il s'assure que l'eau est traitée adéquatement soit par chloration, soit par ébullition. Les Règlements sanitaires internationaux exigent que le cas soit signalé.)
Coqueluche	Séparation du patient des enfants réceptifs et exclusion de l'école et des endroits publics pendant trois semaines après le début des paroxysmes typiques.	Peut retourner à l'école s'il est gardé sous surveillance quotidienne pendant trois semaines.	Non requise. L'immunisation de routine de tous les enfants contre la coqueluche est recommandée.	Éviter les contacts avec les enfants non immunisés.	des pertes provenant du nez et de la gorge et des articles souillés par ces pertes.	Un nettoyage en profondeur est requis	Aucune
Diarrhées des nouveaux-nés (épidémique)	Les enfants infectés et les suspects doivent être isolés pendant la période de contagion.	Requise pour tous les nouveaux-nés contacts	Aucune	Requise	de toutes les pertes et des articles souillés par ces pertes.	Aucune	Deux cas ou plus en même temps dans une pouponnière doivent être considérés comme une épidémie.

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS	LOCAUX ET MILIEU IMMÉDIAT				AUTRES
		Quarantaine	Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	
Diphtérie	Les cas de diphtérie cliniques et suspects doivent être isolés jusqu'à leur guérison clinique et jusqu'à ce que deux cultures de 24 heures d'intervalle, établissent l'absence de bacilles diphtériques. Il peut être mis fin à l'isolement si le micro-organisme s'avère avirulent.	Requise pour tous les contacts intimes jusqu'à ce qu'ils soient prouvés bactériologiquement négatifs, une fois terminé le contact avec le cas ou le porteur.	Les contacts âgés de moins de 10 ans, intimement exposés et non immunisés antérieurement avec une antitoxine, peuvent recevoir une dose prophylactique d'anatoxine. Les personnes immunisées antérieurement devraient recevoir un rappel d'anatoxine.	Requise jusqu'à ce que le médecin hygiéniste lui donne son congé.	de tous les articles en contact avec le patient et de tous les articles souillés par les pertes du patient.	Requise	Les porteurs de diphtérie doivent être isolés de la même façon que les cas de diphtérie. Le médecin hygiéniste peut exiger de tous les contacts d'un cas de diphtérie. Le médecin hygiéniste peut exiger de tous les contacts d'un cas, de même que d'un cas suspect ou d'un porteur de diphtérie qu'il fournisse un prélèvement de la gorge et du nez pour fins d'examen bactériologique. Des prélèvements peuvent aussi être exigés des étudiants qui fréquentent une école où il y a eu un cas, un cas suspect ou un porteur de diphtérie. En cas d'éruption de diphtérie, le médecin hygiéniste peut offrir une immunisation active à toutes les personnes réceptives dans la région affectée par l'éruption.
Dysentérie bacillaire	L'isolement est requis pendant la phase aigue de la maladie. Surveillance des porteurs et interdiction aux porteurs de manipuler les aliments.	Les contacts ne peuvent être employés afin de manipuler des aliments pendant la période de contact ni avant que trois cultures de fèces négatives n'aient été obtenues.	Aucune	Aucune	Élimination salubre des fèces.	Requise	En cas d'épidémie, le médecin hygiéniste prend les mesures nécessaires pour assurer la pureté des aliments, de l'eau et du lait et il fait effectuer des recherches pour retrcer les cas bénins et les porteurs.
Empoisonnement alimentaire Staphylococcique	Aucune	Aucune	Aucune	Aucune	Aucune	Aucune	Le médecin hygiéniste peut rechercher les aliments contaminés aux staphylocoques et les personnes qui manipulent les aliments et qui ont des infections de la peau ou qui sont en phase de porteur nasal. Il peut ordonner la destruction de tout reste de nourriture contaminée après le prélèvement d'échantillons pour fins d'examen en laboratoire.

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS		LOCAUX ET MILIEU IMMÉDIAT			AUTRES
					Désinfection		
		Quarantaine	Immunisation	Quarantaine	Concomitante	Terminale	
Encéphalite équine de l'Ouest	Aucune	Aucune	Aucune	Aucune	Aucune	Aucune	En cas d'épédémie, le médecin hygiéniste peut prendre les mesures nécessaires pour éliminer les moustiques.
Fièvre jaune	Aucune	Aucune	Non requise	Éviter que les moustiques ne parviennent au patient pendant les trois premiers jours en utilisant un filet de lit ou une chambre protégée par des moustiquaires, ou encore en vaporisant les lieux avec un insecticide à effet résiduel.	Aucune	Aucune	(Les Règlements sanitaires internationaux exigent que le cas soit signalé.)
Fièvre récurrente (à poux)	Requise jusqu'à ce que le patient, ses vêtements, tous les contacts du ménage et le milieu immédiat aient subi une désinsectisation.	Requise pendant 15 jours à moins qu'ils ne subissent une désinsectation.	Aucune	Requise jusqu'à ce qu'ils aient subi une désinsectisation.	Déinsectisation requise.		(Les règlements sanitaires internationaux exigent que le cas soit signalé.)
Fièvre typhoïde et paratyphoïde	Requise dans une pièce à l'épreuve des mouches pendant l'attaque aigue. Si le médecin hygiéniste n'est pas convaincu que le patient peut être isolé efficacement autrement, il peut exiger son isolement dans un hôpital adéquat.	Les contacts familiaux ne peuvent être employés à des activités de manipulation d'aliments ou de boissons pendant la période de contact ni avant que des cultures de trois spécimens de fèces et d'urine visant à	Non requise normalement. Le médecin hygiéniste peut recommander que les contacts familiaux, infirmiers et ceux du ménage soient immunisé avec un vaccin puissant. Il peut refuser de donner congé à un porteur de typhoïde ou de paratyphoïde tant que ces contacts n'ont	Le médecin hygiéniste peut ordonner la mise en quarantaine des locaux jusqu'à ce que les mesures qu'il ordonne de prendre pour éviter la propagation de l'infection aient été prises à sa satisfaction.	des fèces, de l'urine, et des articles qu'ils ont souillé.	Requise	La personne qui continue à éliminer des bacilles typhiques ou paratyphiques trois mois après le début de la maladie est considérée porteuse. Un porteur de typhoïde ou de paratyphoïde peut être gardé en quarantaine à moins qu'il ne conclue avec le ministre, au moyen de la formule prescrite par celui-ci, une entente dans laquelle il accepte de se conduire de façon à éviter la propagation de l'infection. Une personne n'est plus considérée porteuse si six cultures consécutives de spécimens authentifiés de fèces, d'urine et de bile duodénale, prises à des intervalles d'un

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS	LOCAUX ET MILIEU IMMÉDIAT				AUTRES
					Désinfection		
		Quarantaine	Immunisation	Quarantaine	Concomitante	Terminale	
		détecter la présence d'organismes typhiques et paratyphiques ne se soient avérées négatives.	pas été immunisés à sa satisfaction.				mois, s'avèrent négatives. Si le médecin hygiéniste peut exiger que le porteur se rende dans un hôpital public pour permettre le prélèvement de spécimens authentiques. Si le médecin hygiéniste soupçonne une source d'alimentation en eau d'être responsable de quelque façon d'une éruption de fièvre typhoïde ou paratyphoïde, il peut ordonner que cette source d'alimentation ne soit pas utilisée à moins que l'eau ne soit chlorée, bouillie, ou traitée d'une autre manière qu'il juge satisfaisante. Si le médecin soupçonne que le lait ou les produits laitiers peuvent être responsables de quelque façon d'une éruption de fièvre typhoïde ou paratyphoïde, il peut en interdire la vente ou l'utilisation tant qu'ils n'ont pas été pasteurisés ou traités d'une autre manière qu'il juge satisfaisante.
Grippe	Non requise sauf sur ordre du médecin hygiéniste.	Aucune	Non requise	Non requise	des pertes provenant du nez et de la gorge du patient.	Aucune	Aucune
Hépatite (infectieuse)	Pendant la première semaine de la maladie	Aucune	Les contacts familiaux peuvent se voir administrer une préparation d'immunoglobuline à raison de 0,02 ml par livre, calculé selon le poids du corps.	Aucune	des fèces, ainsi que des sécrétions du nez et de la gorge.	Aucune	Le médecin hygiéniste s'assure que des mesures sont prises en vue de l'élimination salubre des fèces.
Hépatite (sérique)	Aucune	Aucune	Aucune	Aucune	de l'équipement contaminé par le sang.	Aucune	Le médecin hygiéniste peut exiger que soient stérilisées à fond à la chaleur les seringues et les aiguilles utilisées pour les injections, ainsi que les stylets servant à perforer le doigt. Il peut aussi exiger l'utilisation de seringues, aiguilles ou stylets stériles et distincts pour chaque patient.

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS	LOCAUX ET MILIEU IMMÉDIAT				AUTRES
		Quarantaine	Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	
Infections à rickettsies a) Typhus à poux	Requises jusqu'à ce que le patient, ses vêtements, les pièces d'habitation et les contacts du ménage aient subi une désinsectisation.	Requise pendant 15 jours à moins qu'ils ne subissent une désinsectisation.	Les contacts immédiats peuvent être immunisés.	requises jusqu'à ce qu'ils aient subi une désinsectisation.	Désinsectisation requise.		(Les Règlements sanitaires internationaux exigent que le cas soit signalé.)
b) Fièvre pourprée des Montagnes Rocheuses	Aucune	Aucune	Aucune	Aucune	Élimination	de toutes les tiques	Toutes les tiques sur le patient doivent être éliminées.
c) Fièvre du Queensland	Aucune	Aucune	Non requise	Aucune	du crachat, des excreta, du sang et de tous les articles souillés par ceux-ci	Aucune	Aucune
Infections à salmonella	Interdiction aux personnes infectées de manipuler des aliments et de s'adonner à des activités comportant la garde de jeunes enfants, tant que les cultures de fèces révèlent la présence de salmonelles.	Les contacts familiaux ne peuvent être employés afin de participer à la manipulation des aliments pendant la période de contact et tant que trois cultures de fèces négatives n'ont pas été obtenues.	Aucune	Aucune	élimination salubre des fèces.	Seul le nettoyage de la maison est requis.	En cas d'épidémie, le médecin hygiéniste prend les mesures nécessaires afin d'assurer la pureté des aliments, de l'eau et du lait, et il fait effectuer des recherches afin de retracer les cas bénins et les porteurs.
Infections méningococciques	Jusqu'à 24 heures après le début de la chimiothérapie ou de la guérison clinique.	Aucune. Le médecin hygiéniste peut exiger la mise en quarantaine de contacts à moins que ceux-ci n'aient reçu un traitement prophylactique adé-	Aucune	Aucune	des pertes provenant du nez et de la gorge et des articles souillés par ces pertes.	Un nettoyage à fond est requis.	Aucun

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS		LOCAUX ET MILIEU IMMÉDIAT			AUTRES
		Quarantaine	Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	
		quat, avec un agent antibiotique ou chimiothérapeutique approprié.					
Lèpre	Isolement jusqu'à ce que le médecin hygiéniste lui donne son congé.	Aucune	Aucune	Aucune	des pertes provenant des lésions et des articles souillés par ces pertes.	Requise	Le médecin hygiéniste peut exiger l'isolement à l'hôpital ou dans une léproserie jusqu'à ce que les tests bactériologiques se soient avérés négatifs pendant au moins six mois.
Maladies à transmission sexuelle							Voir la partie II du présent règlement relativement aux procédures de rapport et de gestion des cas et des contacts de maladies à transmission sexuelle.
Maladies contagieuses de la peau a) Pédiculose	Éviction scolaire jusqu'à la désinfection du patient.	Aucune	Aucune	Aucune	Aucune	Aucune	Les autres membres de la famille ou des groupes liés doivent être soumis en même temps à la désinfection.
b) Impétigo	Éviction scolaire jusqu'à ce que le patient ait été traité adéquatement à la satisfaction du médecin hygiéniste.	Aucune	Aucune	Aucune	des pansements et des pertes humides. Désinfecter les vêtements, les serviettes et les draps avant de les laver.	Nettoyage en profondeur.	
c) Teigne tonsurante	Éviction scolaire jusqu'à ce que le patient ait été adéquatement traité.	Aucune	Aucune	Aucune	des pertes, des pansements et des articles qu'ils ont contaminés.	Aucune	
d) Gale	Éviction scolaire jusqu'à la désinfection	Aucune	Aucune	Aucune	Aucune	Aucune	Le médecin hygiéniste peut exiger la désinfection d'autres membres de la famille ou de groupes liés. Les sous-vêtements, les draps et les couvertures doivent être soumis en même temps à la désinfection.

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS		LOCAUX ET MILIEU IMMÉDIAT			AUTRES
		Quarantaine	Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	
Malaria	Aucune	Aucune	Aucune	Aucune	Aucune	Aucune	Remarque : Les moustiques au Manitoba ne sont pas reconnus comme étant des vecteurs de la malaria. Par conséquent, la maladie ne peut normalement se propager dans la province.
Maux de gorge streptococciques et Fièvre scarlatine	Jusqu'à la guérison clinique complète ou jusqu'à ce que le patient ait été traité adéquatement au moyen d'un antibiotique approprié ou d'un agent chimiothérapeutique, de façon à le rendre non-infectieux.	Aucune. Le médecin hygiéniste peut exiger la mise en quarantaine des contacts à moins qu'ils n'aient été soumis à un traitement prophylactique adéquat au moyen d'un antibiotique ou d'un agent chimiothérapeutique approprié.	Non requis	Aucune	des pertes purulentes et des articles souillés par ces pertes.	Nettoyage en profondeur.	En cas d'épidémie, si l'on soupçonne que le lait est le vecteur de la propagation, le médecin hygiéniste peut interdire la vente ou l'utilisation de lait qui n'a pas été pasteurisé ou traité d'une manière qu'il juge satisfaisante.
Méningite aseptique	Requis pendant la période de fièvre	Aucune	Non requise	Aucune	des ustensiles pour manger et pour boire, ainsi que des articles souillés par les sécrétions et les excrétions du patient.	Aucune	Aucune
Oreillons	Jusqu'à ce que l'enflure se soit résorbée.	Aucune	Non requise	Éviter le contact avec les enfants non immunisés.	des ustensiles utilisés pour manger et pour boire; des articles souillés par les sécrétions du nez et de la gorge.	Aucune	

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS	LOCAUX ET MILIEU IMMÉDIAT			AUTRES
		Quarantaine	Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	
Peste	Requise	Les contacts sont soumis à la désinsectisation et à la surveillance pendant six jours.	Non requise	Requise jusqu'à ce que la désinsectisation des rongeurs ait été effectuée à la satisfaction du médecin hygiéniste.	du crachat et des pertes purulentes, ainsi que des articles qu'ils ont souillé; de l'urine et des fèces des patients.	Requise; doit être suivie de fumigation pour détruire les rats et les puces.	En cas d'éruption, le médecin hygiéniste peut exiger que soient prises des mesures en vue de l'élimination des rats et des puces dans la zone touchée. (Les Règlements sanitaires internationaux exigent que le cas soit signalé.)
Poliomyélite	Pendant une semaine à compter de la date du début ou pendant la durée de la fièvre, si elle dure plus longtemps.	Non requise	Non requise. Un vaccin buccal contre la polio, à base de virus vivants inactivés peut être fourni à la communauté, à la discrétion du médecin hygiéniste.	Éviter tout contact avec les enfants et les adultes non immunisés.	des pertes provenant de la gorge et des fèces, ainsi que des articles souillés par ces pertes.	Nettoyage	En cas d'épidémie, le médecin hygiéniste peut ordonner de retarder les interventions facultatives au nez et à la gorge, de même que l'inoculation de tout antigène de type précipité.
Psittacose (Ornithose)	Pendant la phase aigue et fiévreuse de la maladie	Aucune	Aucune	Le médecin hygiéniste peut ordonner la mise en quarantaine des boutiques d'animaux domestiques où il y a eu des cas de psittacose, jusqu'à ce que les oiseaux infectés aient été éliminés ou traités à sa satisfaction, et que les locaux aient été nettoyés à fond.	de toutes les pertes.	Requise pour tous les immeubles abritant les oiseaux infectés.	Le médecin hygiéniste peut ordonner l'élimination de troupeaux de dindes ou d'autres oiseaux si 40 % du troupeaux est atteint d'un virus à virulence élevée et si les animaux ne peuvent être traités d'une manière qu'il juge satisfaisante.
Rage chez les humains	Pendant la durée de la maladie.	Aucune	Aucune	Aucune	de la salive et des articles souillés par la salive.	Aucune	Si un animal soupçonné d'être atteint de la rage mord un être humain, l'incident doit être immédiatement signalé au médecin hygiéniste, qui garde ou fait garder l'animal, vivant et sans lui faire de mal, dans un endroit sûr. L'animal,

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS Quarantaine	LOCAUX ET MILIEU IMMÉDIAT Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	AUTRES
							est gardé au moins 10 jours sous observation. Si l'animal laisse voir des symptômes de rage ou s'il meurt pendant la période d'observation, le médecin hygiéniste fait garder la tête dans la glace et la fait envoyer à un laboratoire reconnu pour fins d'examen. (Les cas de rage chez un animal doivent être signalés à la Division de la santé des animaux du ministère de l'Agriculture du Canada).
Rougeole	Du début de la maladie jusqu'à l'expiration d'une période de quatre jours après l'apparition de l'éruption.	Requise pour les élèves; la période d'incubation est de 14 jours.	Non requise sauf aux fins du paragraphe 261(1) de la Loi sur les écoles publiques.	Exclure les enfants non immunisés.	de tous les articles souillés par les sécrétions du nez et de la gorge.	Un nettoyage à fond est requis.	L'immunisation des élèves est un prérequis à l'admission initiale à l'école.
Rubéole (rougeole allemande)	Aucune	Aucune	Aucune	Aucune	Aucune	Aucune	Interdiction au patient de venir en contact avec des femmes qui sont dans les premiers mois de leur grossesse.
Tétanos	Aucune	Aucune	Aucune	Aucune	Aucune	Aucune	Aucune
Trichinose	Aucune	Aucune	Aucune	Aucune	Aucune	Aucune	Le médecin hygiéniste peut saisir et éliminer tout porc ou produit du porc que l'on croit responsable de l'infection.
Tuberculose	Le médecin hygiéniste peut exiger l'isolement obligatoire des patients atteints de tuberculose infectieuse qui ne peuvent ou ne veulent pas prendre les mesures nécessaires pour éviter la propogation de l'infection.	Aucune	Non requise. Le médecin hygiéniste peut recommander que les contacts qui réagissent négativement à la tuberculine reçoivent le vaccin B.C.G.	Non requise normalement Le médecin hygiéniste peut mettre les locaux en quarantaine s'il existe des circonstances qui à son avis, pourraient promouvoir la propagation de l'infection.	du crachat et des articles souillés par le crachat, y compris les mouchoirs et les serviettes en tissu ou en papier; des ustensiles utilisés par le patient pour manger.	Requise	Il est interdit à quiconque souffrant de tuberculose en phase infectieuse de travailler dans quelque industrie, manufacture ou entreprise où des aliments ou des boissons sont préparés ou offerts en vente. Il est interdit à quiconque gère contrôle, supervise ou est en charge d'un tel établissement de permettre, d'autoriser ou de tolérer qu'une personne souffrant de tuberculose en phase infectieuse y travaille. Il est interdit à quiconque est atteint de tuberculose en phase infectieuse de fréquenter une école, un séminaire, un collège ou une université, ou à quiconque gère, contrôle, supervise ou est en

MALADIE	PATIENT Exigences en matière d'isolement	CONTACTS		LOCAUX ET MILIEU IMMÉDIAT			AUTRES
		Quarantaine	Immunisation	Quarantaine	Désinfection Concomitante	Désinfection Terminale	
							charge d'une telle institution de lui permettre de la fréquenter. Il est interdit à quiconque souffrant de tuberculose en phase infectieuse d'occuper un emploi où il faut toucher de jeunes enfants ou venir en contact étroit avec eux. Si le médecin hygiéniste soupçonne que le lait ou les produits laitiers peuvent avoir quelque chose à voir avec la propagation de la tuberculose, il peut interdire la vente ou l'utilisation de lait ou des produits laitiers tant qu'ils n'ont pas été pasteurisés ou traités d'une manière qu'il juge satisfaisante.
Tularémie	Aucune	Aucune	Aucune	Aucune	des pertes provenant d'ulcères, de ganglions lymphatiques ou du sac conjonctival.	Aucune	
Varicelle	Isolement à domicile et éviction scolaire à compter du début de la maladie jusqu'à l'expiration d'une période de sept jours après l'apparition de la première série de vésicules.	Aucune	Aucune	Prévenir l'entrée en contact des enfants non immunisés.	des articles souillés par les pertes provenant du nez, de la gorge et des lésions	Aucune	Sans objet

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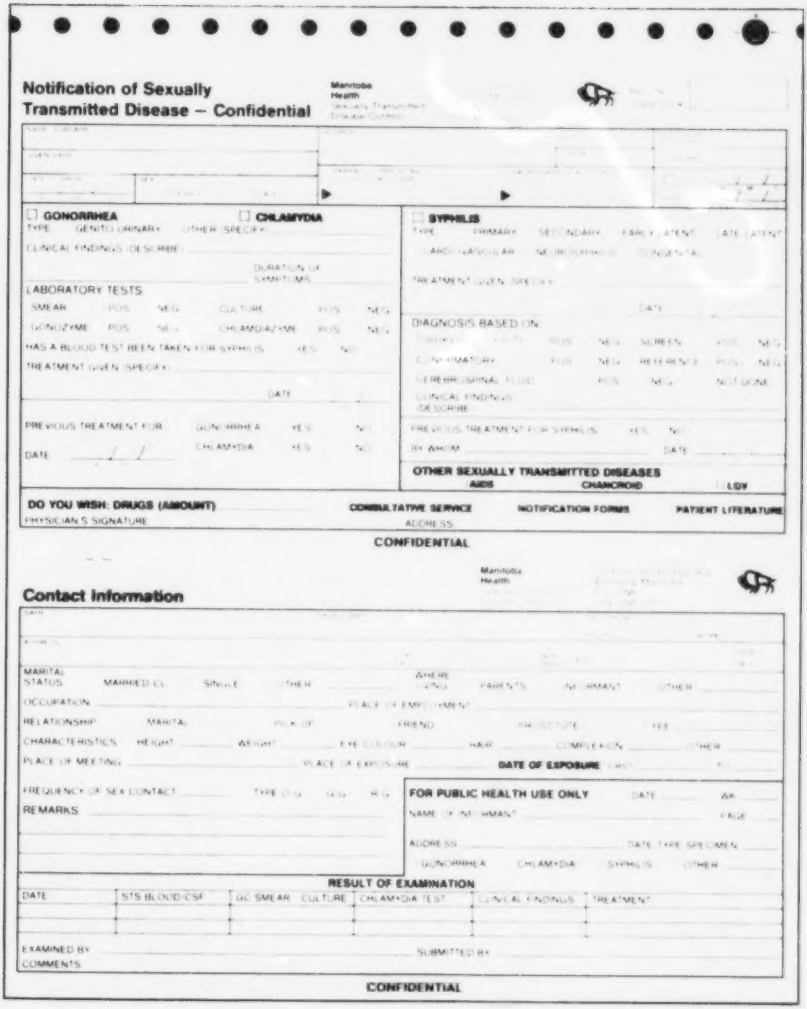
APPENDIX B



Notification of Sexually Transmitted Disease – Confidential

Manitoba Health

☐ GONORRHEA ☐ CHLAMYDIA

TYPE GENITO-URINARY OTHER (SPECIFY)

CLINICAL FINDINGS (DESCRIBE)

DURATION OF SYMPTOMS

LABORATORY TESTS

SMEAR POS NEG CULTURE POS NEG

GONOZYME POS NEG CHLAMIDAZYME POS NEG

HAS A BLOOD TEST BEEN TAKEN FOR SYPHILIS YES NO

TREATMENT GIVEN (SPECIFY)

DATE

PREVIOUS TREATMENT FOR GONORRHEA YES NO

CHLAMYDIA YES NO

DATE / /

☐ SYPHILIS

TYPE PRIMARY SECONDARY EARLY LATENT LATE LATENT

CARDIOVASCULAR NEUROSYPHILIS CONGENITAL

TREATMENT GIVEN SPECIFY

DATE

DIAGNOSIS BASED ON

DARKFIELD POS NEG SCREEN POS NEG

CONFIRMATORY POS NEG REFERENCE POS NEG

CEREBROSPINAL FLUID POS NEG NOT DONE

CLINICAL FINDINGS DESCRIBE

PREVIOUS TREATMENT FOR SYPHILIS YES NO

BY WHOM DATE

OTHER SEXUALLY TRANSMITTED DISEASES

AIDS CHANCROID LGV

DO YOU WISH: DRUGS (AMOUNT) CONSULTATIVE SERVICE NOTIFICATION FORMS PATIENT LITERATURE

PHYSICIAN'S SIGNATURE ADDRESS

CONFIDENTIAL

Manitoba Health

Contact Information

NAME

MARITAL STATUS MARRIED C/L SINGLE OTHER AWARE YES/NO PARENTS INFORMANT OTHER

OCCUPATION PLACE OF EMPLOYMENT

RELATIONSHIP MARITAL PICK UP FRIEND PROSTITUTE FEE

CHARACTERISTICS HEIGHT WEIGHT EYE COLOUR HAIR COMPLEXION OTHER

PLACE OF MEETING PLACE OF EXPOSURE DATE OF EXPOSURE

FREQUENCY OF SEX CONTACT TYPE O-G G-G R-G

REMARKS

FOR PUBLIC HEALTH USE ONLY DATE AR

NAME OF INFORMANT FILE

ADDRESS DATE TYPE SPECIMEN

GONORRHEA CHLAMYDIA SYPHILIS OTHER

RESULT OF EXAMINATION

DATE	STS BLOOD/CSF	GC SMEAR CULTURE	CHLAMYDIA TEST	CLINICAL FINDINGS	TREATMENT

EXAMINED BY SUBMITTED BY

COMMENTS

CONFIDENTIAL

APPENDIX C

DARKFIELD EXAMINATIONS FOR SYPHILIS

Because access to darkfield microscopy facilities for the identification of cases of infectious syphilis is severely limited for both rural and urban physicians, the Cadham Public Health Laboratory offers a "mail-in" slide test. The test is known as the Direct Fluorescent Antibody Treponema Pallidum Test (DFA-TP). A blood specimen for syphilis serology should **always** be taken and submitted simultaneously. In the case of a suspect chancre please note this information on the requisition and an FTA-ABS Test will be performed on the blood sample.

Instructions for Submitting Material for DFA-TP Test

SUSPECT CHANCRE

1. Wear surgical gloves when obtaining specimen.
2. Use a saline-moistened compress to clean lesion.
3. Using a clean saline-moistened compress, gently rub the lesion to obtain a serous exudate but **avoid bleeding**.
4. Collect the exudate either by touching it to the centre of a clean glass bacteriology slide or by means of a fine capillary tube. If a capillary tube is used, transfer contents to several glass slides. A grease pencil circle on the reverse side of the slide would be helpful in indicating location of material. Even more preferable is the use of slides with frosted ends and 2 etched rings on surface.
5. Allow serum on slides to air dry for 30 minutes.
6. Unless slides can arrive at the laboratory the day of collection they should preferably be fixed by immersion in acetone for 10 minutes.
7. Mail slides to Cadham Public Health Laboratory in cardboard slide containers and request DFA-TP test.

APPENDIX D

LABORATORY DIAGNOSIS OF GONORRHEA

Testing: All patients tested for gonorrhea should have a VDRL.

Swabs: Urethra — thin wire shafted cotton tipped applicator Calgiswab or gonozyme swab.

Cervix, Rectum, Throat — cotton tipped wooden or calcium alginate applicator or gonozyme swab for cervix only.

COLLECTION OF SPECIMENS

1. Urethral samples in men are collected by introducing the sampling swab approximately one to two cm up into the urethra, where it is rotated gently before withdrawal. The swab can be moistened in saline before use in order to facilitate its introduction. To increase the chance of recovering *N. gonorrhoea* the patient should not have voided for several hours prior to sampling.
2. To collect samples for gonococcal testing from the cervix, a speculum is introduced into the vagina. The speculum may be moistened with warm water prior to insertion. (Gynecologic creams or lubricants should not be used on the speculum as they may contain an antibacterial ingredient which may destroy gonococci.) The cervix should be cleansed of external exudate. A sampling should be introduced into the endocervical canal and rotated before withdrawal, ten to 30 seconds later. If the hymen is intact, samples are collected from the vaginal orifice.
3. Rectal samples are collected by introducing a sterile swab three to four cm into the rectum. If there is any fecal contamination of the swab, it should be discarded and a repeat specimen obtained.
4. Pharyngeal specimens are obtained by swabbing the posterior pharynx, including the tonsillar areas and faucial pillars.
5. Samples of conjunctival exudate should be collected with a cotton-tipped swab.

I. GRAM STAIN

This method of testing involves testing for dead organisms.

It provides results within 20 minutes if done on site or the same day it is received at the laboratory.

In the female genitourinary tract it is less specific.

Testing Procedure:

Collect secretions from the male urethra by inserting a calcium alginate swab or wire loop.

Gently roll the swab on to a clean glass slide taking care not to rub the swab against the slide destroying the morphology. Allow the slide to air dry and send it to the laboratory appropriately labelled and requisitioned.

II. CULTURE

A. AMIES TRANSPORT MEDIUM WITH CHARCOAL

This transport medium with the addition of charcoal allows for the transportation of the organism to a laboratory. At the laboratory the specimen will be used to inoculate Thayer-Martin culture medium so that the organism can be identified.

Amies medium is available from Cadham Provincial Laboratory or from the laboratory receiving the culture. It is stored at 4°C and has a shelf life of two months. Amies medium should be brought to room temperature prior to use. After inoculation it is maintained at room temperature until it reaches the laboratory for plating onto culture media.

TESTING PROCEDURE:

Insert the sampling swab into the site that requires testing, (See Collection of Specimen section).

Place the swab into the Amies charcoal medium which has been warmed to room temperature. Transport to the laboratory at the same temperature.

B. THAYER-MARTIN (T.M.) CULTURE MEDIUM

This medium is used for the growth of *N. gonorrhoea*. The T.M. culture plate should be stored in the refrigerator at 4°C. Prior to inoculation the medium must be at room temperature and after inoculation should be incubated in a CO_2 incubator for 24 hours at 37°C before being transported to the laboratory at room temperature.

A self-extinguishing candle jar will serve the same purpose as a CO_2 incubator by creating a CO_2 environment. Each time the jar is opened to receive an inoculated culture plate the candle is lit, the lid replaced tightly and allowed to burn out, thus creating CO_2. The candle jar and inoculated plates are kept at room temperature while awaiting transport to the laboratory.

TESTING PROCEDURE:

Collect the specimen as described in the "Collection of Specimen section testing procedure Amies transport media". Having done so, roll the applicator lightly across the culture medium in a Z fashion. Ensure that, all sides of the cotton swab are rolled over the medium. Transport to laboratory at room temperature.

Each site tested (cervix, rectum, pharynx and/or urethra) must be placed on **individual plates** and appropriately labelled and requisitioned.

III. GONOZYME

This test is an enzyme immonunoassay test which detects the *N. gonorrhoeae* antigen.

It is recommended only for genitourinary specimens. Specimens from the pharynx and rectum should be sent in Amies transport media or on Thayer-Martin culture media.

TESTING PROCEDURE FOR GONOZYME:

The STD PEN for males and STD EZE for females are for collection of genitourinary specimens that are to be tested by gonozyme.

Place the provided swab in the endocervix (female) or urethra (male) and leave in site for ten seconds.

Make a smear on a regular microscope glass slide with this swab. Then place the swab in the transport tube and label the tube (gonorrhoeae). Allow the smear to dry, wrap the slide in a cardboard slide holder, attach the slide and transport tube together with an elastic band. Submit the wrapped slide and the STD PEN or EZE to the Cadham Provincial Laboratory.

NOTE: The gonozyme test is useful for eye, cervix or urethral specimens only. The specimens may be kept at room temperature until arrival at the laboratory. Freezing, does not have a deleterious effect on the specimen. Gonozyme must be submitted along with a smear as a check of the specimen quality, and use in the confirmatory test.

APPENDIX E

LABORATORY DIAGNOSIS OF CHLAMYDIA

TESTING

All patients tested for chlamydia should have a VDRL.

TESTS

There are two tests available for detection of *C. trachomatis*.

1. Chlamydiazyme (STD PEN - STD EZE) is an antigen detection test. The test is performed with the same swabs and containers as for gonozyme (see page 90). It is useful only for eye, cervix or urethral specimens. The specimens differ from gonozyme testing in that the gonozyme test requires the pus from the above sites while chlamydiazyme requires the cells lining the conjunctival sac, cervix or urethra. Chlamydiazyme should not be used for throat, anal or vaginal specimens.

2. Microtrak is a fluorescent antibody test. The specimens required are cells from the affected area which are smeared on the centre of a glass microscope slide and air dried. The side smeared should be indicated by a mark (sticky label, china pencil, etc.) and labelled. Microtrak, when clinically necessary, should be used from anal and vaginal sites. Suspected cases of sexual abuse of pre-pubertal children should have microtrak testing when appropriate.

COLLECTION OF SPECIMENS

The female should be in the lithotomy position, and the speculum used to visualize the cervix should be lubricated with warm water.

1. After a specimen for *N. gonorrhoeae* has been taken, place a second appropriate swab in the cervix or the urethra, rotate the swab several complete rotations. This will remove the needed superficial layers of epithelical cells in which chlamydial organisms are located.

If testing is for chlamydia only, make sure the cervix is cleaned of external exudate with a regular swab before taking the specimen.

2. Rectal and pharyngeal specimens are taken as for gonorrhea using microtrak test kit.

3. Place the swab in the provided transport tube and label this tube "chlamydia". Submit the specimen in the tube to Cadham Provincial Laboratory.

APPENDIX F

MANAGEMENT OF ACUTE REACTIONS TO PENICILLIN OR OTHER DRUGS — ANAPHYLAXIS PROTOCOL

MANAGEMENT OF ANAPHYLAXIS

Anaphylaxis, a potentially life-threatening acute systemic allergic reaction to a foreign substance, is extremely uncommon after antimicrobial administration. Nonetheless, clinic staff should have basic knowledge on how to recognize and initiate "first-aid" treatment of this reaction.

Anaphylaxis must be distinguished from simple fainting (vasovagal syncope) which can occur before, during or shortly after injection. Persons experiencing syncope may become pale and feel faint, or they may suddenly collapse unconscious but with a steady pulse and normal respirations. Persons feeling faint should lie flat or sit in the head-down position for several minutes. Persons who faint completely should be placed flat with the feet (**not** the head) somewhat elevated. After they regain consciousness, they should be allowed to rest in a quiet area for ten minutes.

Anaphylaxis usually begins at least several minutes after injection of an offending substance. Initial symptoms typically include several of the following: sneezing, coughing, itching, "pins and needles" sensation of the skin, flushing, facial edema, urticaria ("hives"), and anxiety. In severe cases, these symptoms may be followed by progressive dyspnea (with or without audible wheezing or stridor due to lower and/or upper airway narrowing) and/or hypotension which may progress to shock and collapse, with a weak and fast or irregular pulse.

The following is a guideline for **immediate** "first aid" clinics where more sophisticated medical attention and equipment (oxygen, sphygmomanometer, and intravenous medication) are not immediately available. Nurses can legally initiate these emergency treatment measures.

1. Call emergency medical/paramedic staff.
2. Administer oxygen if immediately available.
3. Apply tourniquet lightly (not so tightly as to stop arterial pulse) above injection site, unless this is impossible (as in deltoid or gluteal area injection).
4. Inject **intramuscularly** into the deltoid (not in the same arm as the injection) aqueous 1:1000 epinephrine (adrenalin) according to the following approximate dosage:

< 12 months	0.05 ml
1-4 years	0.15 ml
5-11 years	0.3 ml
≥ 12 years	0.5 ml

or give 0.01 ml/kg IM for children under 12.

If no improvement occurs within three to four minutes, repeat this intramuscular dose. Monitor respirations, pulse, and (if a sphygmomanometer is available, blood pressure). The same epinephrine dose can be repeated every 10-15 minutes, if needed.

5. As an adjunct to epinephrine (but **not** a replacement), Benadryl (diphenhydramine hydrochloride), 50 mg/ml, can be given once intramuscularly (at a different site than the epinephrine) in the following approximate dosage:

Under age 2 years	0.25 ml
Ages 2-4 years	0.5 ml
Ages 5-11 years	1.0 ml
≥ Age 12 years and adults	2.0 ml

or give 2.5 mg/kg (0.05 ml/kg) IM for children under 12.

PROCAINE REACTIONS

A procaine reaction may occur several minutes after aqueous procaine penicillin has been injected. The clinical features include disorientation, hallucinations, tinnitus and seizures. The patient usually makes a complete recovery within one hour. When the reaction occurs the subject should be placed in a supine position and reassured. The presence of any associated allergic signs would suggest the possibility of a penicillin reaction also being present.

JARISCH — HERXHEIMER REACTION

This is an acute febrile reaction following syphilis therapy in about 50-75% of patients who are being treated for primary and secondary disease. The reaction usually begins four hours after the injection. There is a prodrome during which the patient may suffer non-specific distress, the temperature then rises and there may be an appearance of generalized rash with swelling and tenderness of involved lymph nodes. This reaction reaches a peak about eight hours after the injection and usually has disappeared within 24 hours.

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GLOSSARY

BID	Two times a day
g	Gram
IM	Intramuscular
IUD	Intrauterine device
IV	Intravenous
Kg	Kilogram
mg	Milligrams
PID	Pelvic inflammatory disease
PPNG	Penicillinase-producing *Neisseria gonorrhoea*
QID	Four times a day
STD	Sexually Transmitted Disease